DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

LIFE, ACCIDENT AND HEALTH, Series 4-6

3 CCR 702-4 Series 4-6

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

Regulation 4-6-2 GROUP COORDINATION OF BENEFITS

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this regulation is to:

A. Permit, but not require, plans to include a coordination of benefits (COB) provision unless prohibited by federal law;

B. Establish a uniform order-of-benefit determination under which plans pay claims;

C. Provide authority for the orderly transfer of necessary information and funds between plans;

D. Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first;

E. Reduce claims payment delays; and

F. Require that COB provisions be consistent with this regulation.

Section 3 Applicability

This regulation shall apply to all group health coverage plans issued by carriers licensed to do business in Colorado under Article 14, 16 and 19 of Title 10, C.R.S.

Section 4 Definitions

A. "Allowable expense" means, for the purposes of this regulation, a health care service or expense including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

1. If a plan is advised by a covered person that all plans covering the person are high deductible health plans, and the person intends to contribute to a health savings account established in accordance with 26 U.S.C. § 223 of the Internal Revenue Code, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in 26 U.S.C. § 223(c)(2)(c).

2. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

3. The following are examples of expenses or services that are not an allowable expense:

a. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice or one of the plans routinely provides coverage for private hospital rooms).

b. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit.

c. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.

d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees, or relative value schedule reimbursement, or other similar reimbursement methodology, and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for the specific negotiated fee or payment amount that is different than the primary plan's plan arrangement, and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

4. The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expenses in its contract to services or expenses that are similar to the services or expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of "allowable expense" shall include similar services or expenses to which COB applies.

5. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

6. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

    a. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

    b. Because the covered person has a lower benefit because the covered person did not use a preferred provider.

7. If the primary plan is a closed panel plan with no out-of-network benefits and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were primary when no benefits are available from the primary plan because the covered person uses a non-panel provider, except for emergency services that are paid or provided by the primary.

8. If the two plans are closed panel plans:

    a. The two plans will coordinate benefits for services that are covered services for both plans, including emergency services, authorized referrals, or services from providers that are participating in both plans.

    b. COB does not occur if there is no covered benefit from either plan. This may occur in various circumstances including, if the enrollee did not go to either plan's closed panel of providers, unless there is a covered benefit (i.e. medical emergency, authorized out of network referral, etc.).

    c. If the enrollee obtains services that are covered benefits of the primary plan, the secondary carrier shall coordinate benefits only to the extent that there are benefits or reserves available.

    d. If the service is not a covered benefit of the primary plan but the service is a covered benefit of the secondary plan (i.e. the Covered Person went to a provider who does not participate with the primary plan and the service is not due to a medical emergency), (i.e., the Covered Person went to a provider who does not participate with the primary plan the service is not due to a medical emergency), the secondary plan will pay benefits as though they are primary.

B. "Birthday" means, for the purposes of this regulation, only to the month and day in a calendar year and does not include the year in which the individual was born.

C. "Catastrophic plan" shall have the same meaning as found at § 10-16-102(10).

D. "Claim" means, for the purposes of this regulation, a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

1. Services (including supplies);

2. Payment for all or a portion of the expenses incurred;

3. A combination of Paragraphs 1 and 2 above; or

4. An indemnification.

E. "Claim determination period" means, for the purposes of this regulation, a period of not less than twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide.

1. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

2. As each claim is submitted, each plan determines its liability and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

F. "Closed panel plan" means, for the purposes of this regulation, a health maintenance organization (HMO), preferred provider organization (PPO) or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel provider.

G. "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means, for the purposes of this regulation, coverage provided under a right of continuation pursuant to federal law.

H. "Coordination of benefits" or "COB" means, for the purposes of this regulation, a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

I. "Custodial parent" means, for the purposes of this regulation, the parent awarded sole custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than half the calendar year without regard to any temporary visitation.

J. "Group-type contract" means, for the purposes of this regulation, a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

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

L. "High-deductible health plan" has the meaning given the term under 26 U.S.C. § 223, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

M. "Hospital indemnity benefits" means, for the purposes of this regulation, benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

N. "Limited benefit plan" 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 plans do not include short-term limited duration health benefit policies, contracts or certificates, high-deductible health benefit plans, or catastrophic plans. Such non-supplemental plans are included under the term of "health benefit plan."

O. "Plan" means, for the purposes of this regulation, a form of coverage with which coordination is allowed or required. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

1. If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract.

2 The definition shown in the model COB provision in Appendix A is an example of how a plan may be defined, but any definition that satisfies this subsection may be used.

3. This regulation uses the term "plan." However, a contract may use "program" or some other term that meets the definition of a plan.

4. Plan may include:

a. Group insurance contracts and group subscriber contracts;

b. Uninsured arrangements of group or group-type coverage;

c. Group coverage through closed panel plans;

d. Group-type contracts;

e. The medical care components of group long term care contracts, such as skilled nursing care;

f. The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts;

h. Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph 4.i. below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and

i. Group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

5. Plan shall not include:

   a. Hospital indemnity coverage benefit other than fixed indemnity coverage;

   b. Accident only coverage;

   c. Specified disease or specified accident coverage;

   d. Limited benefit plans, as defined in Section 4.N.;

   e. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

   f. Benefits provided in group long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

   g. Medicare supplement policies;

   h. A state plan under Medicaid; or

   i. A governmental plan which, by law, provides benefits in excess of those of any private insurance plan or other non-governmental plan.

P. "Primary plan" means, for the purposes of this regulation, a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following is true:

   1. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or

   2. All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Q. "Secondary plan" means, for the purposes of this regulation, a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

R. "This plan" means, in a COB provision, the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from this plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with similar benefits, and may apply another COB provision to coordinate with other benefits.

Section 5 Coordination of Benefits Contract Provisions

A. Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of Subsections B, C and D of this section and to the provisions of Section 6.

B. Appendix B is a plain language description of the COB process that explains to the covered person how carriers will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two (or more) plans will pay for or provide benefits.

C. The COB provision (Appendix A) and the plain language explanation (Appendix B) do not have to use the specific words and format shown in Appendix A or Appendix B. Changes may be made to fit the language and style of the rest of the group contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

1. Another plan exists and the covered person did not enroll in that plan;

2. A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

3. A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

E. No plan may contain a provision that its benefits are “always excess” or “always secondary” except in accord with the rules permitted by this regulation.

F. No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under Section 4.O. of this regulation.

Section 6 Rules for Coordination of Benefits

A. When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

2. If the primary plan is a closed panel plan, and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary provider

3. When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan’s compliance with this regulation.

4. If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plan benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan, or plans, and the benefits of any other plan, which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

5. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider, with the exceptions of medical emergencies and if there are allowable benefits available. In most instances, COB does not occur if a covered person is enrolled in two (2) or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the claim determination period when the covered person receives emergency services that would have been covered by both plans.

B. Except as provided in Section 6.A.1., a plan that does not contain order of benefit determination provisions that are consistent with this regulation will always be the primary plan, unless the provisions of both plans, regardless of the provisions of this paragraph, state that the plan is primary.

Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.

D. Order-of-Benefit Determination

Each plan determines the order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent

The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person, as a dependent, is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

a. Secondary to the plan covering the person as a dependent; and

b. Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a. For a dependent child whose parents are married or are living together, whether or not they have been married:

(1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(2) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If the court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no health care coverage for the dependent child's health care, but that parent's spouse does, the spouse's plan is primary. This item shall not apply with respect to a plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

(2) If the court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Section 6.D.2.a. shall determine the order of benefits.

(3) If the divorce decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the depend child, the provisions of Section 6.D.2.a. shall determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses of health care coverage, the order of benefits for the child are as follows:

(a) The plan of the custodial parent;

(b) The plan of the spouse of the custodial parent;

(c) The plan of the noncustodial parent; and then

(d) The plan of the spouse of the noncustodial parent.

c. For a dependent child covered under more than one plan of individuals who are not parents of the child, the order of benefits shall be determined, as applicable, under Section 6.D.2.a. or b. as if those individuals were the parents of the child.

d. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Section 6.D.5. applies.

In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Section 6.D.2.a. to the dependent child's parent(s) and the dependent's spouse.

3. Active Employee or Retired or Laid-Off Employee

a. The plan that covers a person as an active employee, who is neither laid off nor retired, or as a dependent of an active employee, is the primary plan.

b. If the secondary, or other plan, does not have this rule, and as result the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the rule in Section 6.D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage

a. If a person whose coverage is provided pursuant to COBRA, or under a right of continuation pursuant to state or federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree, is the primary plan and the plan covering that same person pursuant to COBRA, or under a right of continuation pursuant to state or other federal law, is the secondary plan.

b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the rule in Section 6.D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage

a. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

b. To determine the length of time a person has been covered under a plan, two (2) successive plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

c. The start of a new plan does not include:

(1) A change in the amount or scope of a plan's benefits;

(2) A change in the entity that pays, provides or administers the plan's benefits; or

(3) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

d. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. If none of the preceding rules determine the primary plan, the allowable expenses shall be shared equally between the plans.

Section 7 Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim

In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by that amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Section 8 Notice to Covered Persons

A plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

Section 9 Miscellaneous Provisions

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

1. A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (noncomplying plan) on the following basis:

   a. If the complying plan is the primary plan, it shall pay or provide its benefits first;

   b. If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

   c. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly.

2. If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.

3. In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.

B. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

C. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary.

Section 10 Effective Date for Existing Contracts

A. This regulation is applicable to every group health care coverage plan that provides health care benefits and that was issued on or after the effective date of this regulation.

B. A group health coverage plan that provides health care benefits and that was issued before the effective date of this regulation shall be brought into compliance with this regulation by the later of:

1. The next anniversary date or renewal date of the group contract; or

2. Twelve (12) months following the effective date of this regulation; or

3. The expiration of any applicable collectively bargained contract pursuant to which it was written.

C. For the transition period between the adoption of this regulation and the timeframe for which plans are to be in compliance, pursuant to Subsection A, a plan that is subject to the prior COB requirements shall not be considered a non-compliant plan by a plan subject to the new COB requirements. If there is a conflict between the prior COB requirement under the prior regulation and the new COB requirements under the amended regulation, the prior COB requirements shall apply.

Section 11 Severability

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

Section 12 Incorporated Materials

26 U.S.C. § 223, published by Government Printing Office shall mean 26 U.S.C. § 223 as published on the effective date of this regulation and does not include later amendments to or editions of 26 U.S.C. § 223. A copy of 26 U.S.C. § 223 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A Certified copy of 26 U.S.C. § 223 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.gpo.gov.

Section 13 Enforcement

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

Section 14 Effective Date

This regulation is effective January 1, 2014.

Section 15 History

Regulation 78-6, was effective March 1, 1972.
Regulation 78-6, was amended and reenacted July 1, 1979.
Regulation 78-6, was amended effective May 15, 1986.
Regulation 78-6 was repealed and replaced by Regulation 4-6-2, effective July 1, 1993.
Regulation 4-6-2 was repealed and repromulgated effective July 1, 2002.
Sections 2, 4(3)(g), 13 and 14 amended effective February 1, 2004.
Amended Regulation, effective September 1, 2010.
Repealed and Repromulgated Regulation, effective January 1, 2014.

APPENDIX A MODEL COB CONTRACT PROVISIONS COORDINATION OF THIS GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits, so that all plan benefits do not exceed 100% of the total Allowable expense.

D. "Allowable expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the Plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. "Claim determination period" is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

F. "Closed panel plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

G. "Custodial parent" means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

B.

(1) Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

D. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

(1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent;
- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. [Organization responsibility for COB administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. [Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, [Organization responsibility for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. [Organization responsibility for COB administration] will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsibility for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

APPENDIX B CONSUMER EXPLANATORY BOOKLET COORDINATION OF BENEFITS

IMPORTANT NOTICE
This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your carriers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first.

Any plan which does not contain your state's coordination of benefits rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when;

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for the health care expenses of your child who is covered by this plan and

- You are married and your birthday is earlier in the year than your spouse's or you living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule";

  or

- you are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses;

  or

- There is no court decree, but you have primary custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMO) and preferred provider organizations (PPO) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.
- If the primary plan covers similar kinds of health care, but allows expenses that we do not cover, we may pay for those expenses. We will not pay an amount the primary plan didn't cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions About Coordination of Benefits?

Colorado Division of Insurance
1560 Broadway, Ste 850
Denver, CO 80202
Phone Number: 303-894-7490 or 1-800-930-3745

Regulation 4-6-3 CONCERNING COVERCOLORADO STANDARDIZED NOTICE FORM AND ELIGIBILITY REQUIREMENTS [Repealed eff. 01/01/2014]

Regulation 4-6-5 CONCERNING SMALL EMPLOYER GROUP HEALTH BENEFIT PLANS, THE BASIC AND STANDARD HEALTH BENEFIT PLANS, AND PREVENTIVE SERVICES [Repealed eff. 11/01/2013]

Regulation 4-6-7 CONCERNING PREMIUM RATE SETTING FOR SMALL GROUP HEALTH PLANS

Section 1 Authority

This regulation is promulgated under the authority of § §10-1-109(1), 10-16-102(10)(b)(II), 10-16-104.9, 10-16-105(6.5), 10-16-105(7.2), 10-16-105(8)(f), 10-16-105(8.5) and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish and implement rules for setting premiums for small group health benefit plans. This regulation concerns: applicability and scope of Colorado's small group health rating laws; carriers' obligations to provide coverage; premium rate setting; use of composite rates; rate filings; and actuarial certifications.

Section 3 Applicability

This regulation shall apply to all small group carriers and health benefit plans subject to the small group laws of Colorado.

Section 4 Definitions

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

B. "Metropolitan statistical area (MSA)" is a relatively freestanding area of the state determined by one or more large population nuclei, together with adjacent communities, that have a high degree of economic and social integration with the nuclei. Each MSA is not closely associated with another MSA. An MSA is a statistical standard developed for use by the Federal Office of Management and Budget, following a set of officially published standards, including, but not limited to, the acceptable underlying population base.

C. "Premium rate," "rate" and "premium" mean all moneys paid by a small 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.

D. "Primary metropolitan statistical area (PMSA)" is a possible subcategory of an MSA, which has a million or more persons living in that MSA. The PMSA consists of a large urbanized county or cluster of counties that demonstrate very strong internal economic and social links, in addition to close ties, to other portions of the larger area. Each PMSA is also determined by the Federal Office of Management and Budget following a set of officially published standards, including, but not limited to, the acceptable underlying population base.

E. "Qualified actuary" means an actuary who meets the requirements of Colorado Insurance Regulation 1-1-1.

F. "Renewed." A health benefit plan is deemed renewed upon the occurrence of the earliest of: the 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.

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

Section 5 Premium Rate Setting

A. Calculating Premium Rates Adjusted for Case Characteristics

1. Index Rate - Each carrier offering a health benefit plan to groups in Colorado shall develop a single index rate for all small group plans it offers. This single index rate is identical to a community rate for the company's universe of small group plans offered for new issue or renewal. It should be calculated using the experience for all small group plans. The premium rate charged during a rating period, applicable to all small employers, shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this Section 5.

2. Plan Design Adjustment - The Index Rate may be adjusted to reflect differences attributable to different plan designs. If the small employer carrier elects to make this adjustment, the small employer carrier should calculate a rate adjustment factor for each small group plan design. Differences in the rates for different benefit plans, for persons with the same case characteristics of age, geographic location and family size, shall be attributable to plan design only. Using this methodology, a carrier's rates for a plan with richer benefits than the Colorado Standard Health Benefit Plan should be higher than the rates for its Colorado Standard Health Benefit Plan, and a carrier's rates for a plan with leaner benefits than the Colorado Standard Health Benefit Plan should be lower than the rates for its Colorado Standard Health Benefit Plan.

3. Acceptable Case Characteristic Factor Categories - For all small employer policies carriers choosing to modify the unique index rate by the use of case characteristics must utilize one or more of the categories listed below. Carriers shall develop a rating factor for each category, which is actuarially based.

a. Age - if a carrier uses age to calculate rates, then it shall use the following 12 mandatory age categories. Rates must be based on employee age only, not employee and spouse ages.

Mandatory Age Categories
Children ages newborn through age 19 (or through age 24 if the child is a full-time student covered as a dependent), excluding emancipated minors
Emancipated minors and persons ages 20 through 24
Age 25 through 29

Age 30 through 34
Age 35 through 39
Age 40 through 44
Age 45 through 49
Age 50 through 54
Age 55 through 59
Age 60 through 64
Age 65 and older: Medicare is primary payer
Age 65 and older: Medicare is secondary payer

b. Geographic Location - if a carrier uses geographic location to calculate rates, then it shall use the 9 mandatory categories listed below. In determining that these geographic location categories best serve the public interest, the commissioner considered the key issues of accessibility, availability, consumer choice and the cost of health care in all areas of the state. Public and consumer input was solicited, received, and evaluated. The commissioner determined that these area groupings best serve the public interest by maximizing consumer choice options and health care availability in all areas of the state at the lowest possible cost and will ensure that the rates charged are not excessive, inadequate or unfairly discriminatory. The appropriate population base for these categories is the base as determined by the federal government in establishing MSAs, except for the last two categories listed below. No MSA exists for these counties and consequently these counties were grouped by population size. Carriers may, with the prior written approval of the commissioner, establish one or more additional categories by further subdividing the last two categories.

Rates must be based on the primary physical location of the small employer's business, except that an employer with multiple business locations in separate geographic categories may be provided with separate rates for each physical business location. There cannot be a separate factor for a small employer's out-of-state employees, if any. These individuals shall be rated as if they are working in the small employer's primary physical business location.

Mandatory Geographic Location Categories
Boulder County (known as the Boulder-Longmont PMSA)
Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties (known as the Denver MSA)
Weld County (known as the Greeley PMSA)
El Paso County (known as the Colorado Springs MSA)
Larimer County (known as the Fort Collins-Loveland MSA)
Mesa County (known as the Grand Junction MSA)
Pueblo County (known as the Pueblo MSA)
Counties in Colorado with a population of 20,000 or fewer residents: Alamosa, Archuleta, Baca, Bent, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Lake, Las Animas, Lincoln, Mineral, Moffat, Otero, Ouray, Park, Phillips, Pitkin, Prowers, Rio Blanco, Rio Grande, Saguache, San Juan, San Miguel, Sedgwick, Washington, and Yuma counties. (Such counties may be grouped into one or more geographic location categories based on differences in medical costs of the carrier with the prior written approval of the Commissioner.)
All other Colorado counties: Delta, Eagle, Elbert, Fremont, Garfield, La Plata, Logan, Montezuma, Montrose, Morgan, Routt, Summit, and Teller counties. (Such counties may be grouped into one or more geographic location categories based on differences in medical costs of the carrier with the prior written approval of the Commissioner.)

PMSA = Primary Metropolitan Statistical Area

MSA = Metropolitan Statistical Area

(1) Geographic rating factors must be determined on the same basis, reflect the relative differences in expected costs, and produce rates that are not excessive, inadequate, or unfairly discriminatory in such geographic areas. For example, a geographic factor of 1.2 for the Colorado Springs MSA and a factor of 1.0 for the Denver MSA would imply that costs can reasonably be expected to be 20% higher in the Colorado Springs MSA than they are in the Denver MSA. All changes in the geographic rating factors must be supported on this basis.

(2) Approval to subdivide categories eight and nine above into two or more subcategories must be obtained in advance. The material provided to support the subdivision(s) shall be based upon statistically-credible data using the Division of Insurance's credibility standard and/or other actuarially-determined standards. The Division's credibility standard is 2,000 life-years and 2,000 claims per year. (See Section 6(M) of Amended Colorado Insurance Regulation 4-2-11).

c. Family Size - if a carrier uses family size to calculate rates, then it shall use the 4 mandatory categories listed below. If age is also used as a rating factor, rates must be based on employee age only, not employee and spouse ages.

Mandatory Family Size Categories
1 adult
2 adults
1 adult plus any number of children who are dependents of the primary insured or for whom the primary insured is legally required to provide health insurance coverage.
2 adults plus any number of children who are dependents of the primary insured or for whom the primary insured is legally required to provide health insurance coverage.

d. Tobacco Use - If a carrier reflects tobacco usage in the calculation of rates, then it shall do so according to the following requirements:

(1) The carrier shall provide a wellness and prevention program;

(2) Any individual who participates in the program shall be given the lower rate;

(3) Any rate adjustment attributable to an individual (and all similarly situated individuals) based upon tobacco usage shall be applied to that individual (and all similarly situated individuals), and shall not be distributed to the entire group; and,

(4) The carrier shall use one of the following three allowable rate adjustments:

(a) An increase of up to fifteen percent (15%) for tobacco use, pursuant to § 10-16-105(8.5)(a)(I)(B), C.R.S.;

(b) A decrease of up to fifteen percent (15%) for nonuse of tobacco, pursuant to § 10-16-105(8.5)(a)(I)(B), C.R.S.; or,

(c) A discount of up to ten percent (10%) for refraining from smoking for more than twelve (12) consecutive months prior to the effective date or renewal date of the small group policy, pursuant to § 10-16-105(13)(c), C.R.S.

e. Standard Industrial Classifications - If the carrier uses the standard industrial classifications to calculate rates, only one factor is permitted for each small group. No enrolled employee should be charged directly for any such adjustment.

f. All rating adjustments due to the application of any of these case characteristics must be applied consistently in the calculation of all small employers' rates. Any adjustments made due to standard industrial classification should be applied uniformly to the rates charged for all employees enrolled under each small group policy.

g. All rate filings must contain adequate and acceptable detail information as to how each of the rating factors used for tobacco use and standard industrial classification is determined and the combined maximum and minimum effect of applying these rating factors.

h. Health status and claims experience may not be used as case characteristics. A health questionnaire, requesting reasonable information, may be used to obtain information about the health status of group enrollees. However, the health questionnaire may not be used in any way to determine the premium rate or any rating factor that is used in the determination of the premium rate that is charged to the group, except as provided in Subparagraph (d) of this paragraph.

4. Limits on Certain Case Characteristic Adjustments - For all small group health benefit plans issued or renewed for a small employer on or after January 1, 2008, rating adjustments based on standard industrial classification shall not result in a rate that deviates from the carrier's filed rate by more than a ten percent (10%) increase or a twenty-five percent (25%) decrease.

5. Limits on Renewal Rates - A small employer carrier may make an upward adjustment to a small employer's renewal premium not to exceed fifteen percent annually due to standard industrial classification or tobacco use. The final rate is subject to the limits on rating adjustments specified under Section 5(A)(4) of this regulation.

6. 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 months, in certain instances. (See §10-16-105 (13)(a)(I) and §10-16-105(14)(a), C.R.S.) Adequate and acceptable detail information as to how the carrier determines the rating factor(s) for this adjustment should be included in each rate filing.

7. Wellness and Prevention Programs - A small employer carrier may make available wellness and prevention programs as provided for under Section 7B of Colorado Insurance Regulation 4-2-11.

B. Rating Period

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

1. A small employer carrier specifies in its rate filings a different rating period, which shall be the same for all its small group health benefit plans issued or renewed in the same calendar month, pursuant to §10-16-105(8)(c)(II), C.R.S.; and

2. The small employer carrier clearly discloses in all its small employer solicitation and sales materials exactly what the different rating period is, pursuant to §10-16-105(5)(b), C.R.S.

C. Administrative and Other Fees

Carriers and producers shall not charge any fees in addition to premium, except for amounts charged as necessary to recoup assessments paid for CoverColorado. 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.

Section 6 Use of Composite Rates

A. Small employer carriers may offer the small employer rates calculated by use of the following methods subject to the following restrictions:

1. Four-tier family, age-banded rates calculated pursuant to Section 5 of this regulation; OR

2. A choice between four-tier, age-banded rates, calculated pursuant to Section 5 of this regulation, and composite rates. It shall be construed that the small employer carrier has offered the small employer a choice between the two methods if, at initial application and at each renewal:

a. Both methods are offered to the small employer, with the differences clearly explained in writing; OR

b. The small employer is given a written option to indicate that: 1) both rating methods need be presented; or 2) only age-banded rates need be presented; or 3) only the composite rate need be presented. This indication may be a check-off on the application or renewal form or other similar form that complies with this section.

B. Small employer carriers may offer small employers composite rates as an alternative to four-tier, age-banded rates calculated pursuant to Section 5 of this regulation if all of the following conditions are met:

1. The small employer carrier makes the same offer across its entire book of Colorado small group business where an employer has ten (10) or more eligible employees. If the small employer carrier makes this offer to all small employers having ten (10) or more eligible employees, then the small employer carrier may also offer composite rates to small employers having fewer than ten (10) eligible employees. The small employer carrier must establish a pre-determined minimum size for offering composite rates. The same offer must be made available to all small employers having at least this pre-determined number of eligible employees.

2. The small employer carrier must clearly state on its application and renewal forms for all of its small group products the differences between age-banded and composite rates and that either:

a. The minimum number of eligible employees for calculating composite rates is ten (10) and that all small employers with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates, and have the right to see them calculated either or both ways; OR

b. If the number of minimum eligible employees is less than ten (10), the small employer carrier shall state the minimum number and that all small employers with at least this minimum number of eligible employees are entitled to a choice of composite rates or four-tier, age-banded rates, and have the right to see them calculated either or both ways.

3. Calculating Composite Rates:

a. New Policies - At the time of the initial application by the small employer, composite rates must be calculated separately for each small employer, based upon the small employer's actual enrollment as of the effective date.

b. Renewing Groups - At renewal, composite rates must be calculated for each small employer group based on enrollment as of the date of the renewal calculation, or as of the effective date for the renewal rates, which shall be consistent for all small employers. A second quote, subsequent to the date of the renewal calculation, may be calculated IF the demographics of the small group have changed significantly since the date of the original renewal quote, and the carrier recalculates the composite rates in all similar circumstances. If the carrier retains the right to revise the original calculation, this right must be clearly disclosed. Despite changes in the demographic composition of the small employer group, composite rates shall be set, as of the renewal date, for a particular small employer for the entire rating period.

4. The small employer carrier uses the same composite rating methodology for all small employers. The small employer carrier may offer composite rates on a two tier (i.e. employee and employee plus dependents), three tier or four tier composition basis. If the small employer carrier elects to offer these three choices, it is at the employer's sole discretion whether the composite rates are set on the two-tier, three-tier, or four-tier family composition basis. However, the basis for the calculation of initial premiums before composite rating for a particular employer must be based on four-tier family, age-banded rates calculated pursuant to Section 5 of this regulation.

5. At the time of the initial application by the small employer, the composite rating and four-tier family, age-banded rating for a particular small employer must result in identical total premium collections due from that employer for the first month of the rating period. At renewal, the composite rating method and four-tier family, age-banded rating methods for each small employer must result in identical total premium amounts as of the date of the renewal calculation. Assuming there is no change in the demographic composition of the small employer group, composite rating and four-tier family, age-banded rating for a particular employer must result in identical total premium collections due from that employer for a given rating period.

C. Nothing in this section shall be construed to require carriers to provide other than four-tiered, age-banded rates.

Section 7 Rate Filings and Actuarial Certification

A. The provisions of § §10-16-105(6), 10-16-105(6.5) and 10-16-107, C.R.S., and Colorado Insurance Regulation 4-2-11 shall apply to the filing of rates for small employer health benefit plans. Expected rate increases for small employer health benefit plans shall be submitted for approval to the Division of Insurance at least 60 days prior to the proposed implementation of the rates.

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

C. Pursuant to §10-16-105(6.5), 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 of Insurance prior to March 1 of each calendar year. Note - this certification may be combined with the Company's Annual Rate Report. (See Section 8 of Amended Colorado Insurance Regulation 4-2-11.) 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.

Section 8 Enforcement

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

Section 9 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 10 Effective Date

This regulation is amended effective January 1, 2011.

Section 11 History

Emergency Regulation 94-E-4; Effective October 20, 1994.
Emergency Regulation 95-E-2; Effective January 20, 1995.
Hearing date: December 8, 1994; Effective March 1, 1995.
Hearing date: April 2, 1998; Effective June 1, 1998, Amended Sections 2, 3, 4, 5, 6, 7 & 10.
Hearing date: October 2, 2000; Effective January 1, 2001, Amended Sections 5 & 6.
Hearing date: September 4, 2002; Effective January 1, 2003.
Hearing date: February 4, 2003; Effective March 31, 2003, Amended Sections 1, 5, 10 & 11.
Emergency Regulation 03-E-6, Effective September 1, 2003.
Hearing date: October 1, 2003; Effective December 1, 2003, Amended Sections 4, 5, 6, 7, 10 11.
Hearing date: February 2, 2004; Effective April 1, 2004, Amended Sections 5, 10, & 11.
Hearing date: August 4, 2004; Effective September 30, 2004.
Hearing date: October 10, 2007; Effective January 1, 2008, Amended Sections 5, 7, 10, & 11.
Hearing date: August 5, 2008; Effective October 1, 2008, Amended Sections 5, 7, 10 & 11.
Emergency Regulation 08-E-10, Effective January 1, 2009.
Hearing date: December 9, 2008; Effective February 1, 2009, Amended Sections 5, 10 & 11.
Amended Regulation 4-6-7, Effective January 1, 2011.

Regulation 4-6-8 CONCERNING SMALL EMPLOYER GROUP HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-16-105.2(1)(a)(IV), 10-16-108.5(8), 10-16-109, and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for implementing Colorado's small group laws. This regulation concerns the applicability and scope of the small group provisions; carriers' obligations to provide coverage; employee eligibility requirements; the use of restrictive riders; rules relating to fair marketing; and carrier disclosure requirements.

Section 3 Applicability

A. This regulation applies to any health benefit plan, whether provided on a group, group association, or individual basis, which:

1. Meets one or more of the conditions set forth in § 10-16-105.2(1)(a)(I) through (IV), C.R.S., except as provided in § § 10-16-105.2(1)(d) and 10-16-105.2(1.5), C.R.S., and subsection 3.J. of this regulation; and

2. Provides coverage to the employees of a Colorado small employer, without regard to whether the policy or certificate was issued in this state, except as provided in § 10-3-903(2)(h), C.R.S.

B. A carrier that provides individual or group health insurance coverage to one or more of the employees of a small employer shall be considered a small employer carrier subject to the provisions of this regulation if it meets any of the conditions found in § 10-16-105.2(1)(a)(I) through (IV), C.R.S., except as provided in § § 10-16-105.2(1)(d) and 10-16-105.2(1.5), C.R.S.

C. The provisions of this regulation shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size or is sponsored by an association, health care coverage cooperative or discretionary group, except as provided in § § 10-16-105.2(1)(b) and 10-16-214(5), C.R.S.

D. If a small employer is issued a health benefit plan subject to the small group health insurance laws of Colorado, the provisions of this regulation and statutes concerning small group health insurance shall continue to apply to the health benefit plan in the event that the small employer subsequently employs more than one hundred (100) eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) calendar days of becoming aware that the employer no longer meets the definition of a small employer, but no later than the anniversary date of the employer's health benefit plan, notify the employer that the small employer health insurance provisions of Colorado law shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

E. If a health benefit plan is issued to an employer with more than one hundred (100) eligible employees that is not a small employer but subsequently the employer becomes a small employer (e.g., due to the loss or change of work status of one or more employees), the provisions of this regulation and statutes concerning small group health insurance shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier solely because the carrier continues to provide coverage under the health benefit plan to the employer. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has one hundred (100) or fewer eligible employees, notify the employer of the options and protections that may be available to the employer under the small group health insurance laws of Colorado, including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

F. Employees in more than one state.

1. If the primary business location of the small employer is in this state, then the provisions of this regulation and statutes concerning small group health insurance shall apply to the health benefit plan issued to such a small employer, except as provided under § 10-3-903(2)(h), C.R.S.

2. If a health benefit plan is subject to the small group health insurance laws of Colorado, this regulation and relevant statutes shall apply to all individuals covered under the health benefit plan.

G. A carrier that is not operating as a small employer carrier in this state shall not become subject to Colorado's small group health insurance laws solely because a small employer that was issued a health benefit plan in another state, by that carrier, moves to this state.

H. A plan marketed to individual employees through an employer, or at an employer's place of business, is subject to this regulation and all applicable small group laws unless a carrier can demonstrate that the circumstances of the sale, marketing, and continuation of such plan coverage meet the conditions established in § 10-16-105.2(1)(a) or (d), C.R.S., and as further defined in subsection 3.J. of this regulation.

I. A health benefit plan which meets the criteria listed in section 3.A. of this regulation shall be subject to small group requirements even if that health benefit plan covers a single person. Examples include, but are not limited to:

1. A health benefit plan that covers the sole eligible employee of a small employer;

2. A health benefit plan that covers just one employee because the other employees of a small employer, who have coverage under another health benefit plan, have waived off the plan; or

3. A health benefit plan that covers the only employer-determined eligible employee of a small employer.

J. Pursuant to the authority granted to the Colorado Division of Insurance (Division) under § 10-16-105.2(1)(a)(IV), C.R.S., this regulation shall not apply to health benefit plans marketed by producers through an employer or at an employer's place of business to individual employees if all of the following conditions are met both at the time of marketing and sale, and continuously during the period of coverage:

1. No portion of the premium or benefit is paid by or on behalf of a small employer, except as permitted in § 10-16-105.2(1.5), C.R.S.;

2. No person covered by the health benefit plan is reimbursed, whether through wage adjustments or otherwise, by or on behalf of a small employer for any portion of premium, except as permitted in § 10-16-105.2(1.5), C.R.S.;

3. The health benefit plan is not treated by the employer or anyone covered by the plan who meets the definition of an eligible employee or dependent of an eligible employee as part of a plan or program for the purposes of Section 106, 125, or 162 of the federal Internal Revenue Code of 1986, as amended, except as permitted in § 10-16-105.2(1)(d), C.R.S.;

4. If the health benefit plan is marketed to an employer's ineligible employees through an employer or at a place of business this marketing occurs only with the written permission or at the written request of the employer;

5. There is an employer-sponsored health benefit plan already in place at the place of business where the health benefit plan is being marketed;

6. No billings, premium collections or other correspondence regarding the health benefit plan are sent to the place of business or otherwise involve the employer; and

7. The employee being marketed and/or sold the health benefit plan meets one or more of the following criteria:

   a. The employee will be terminating employment within thirty-one (31) days;

   b. The employee is a seasonal employee with an employment contract that is shorter than the waiting period for coverage or is not eligible for coverage under his/her employer's health benefit plan;

c. The employee is a temporary or substitute employee;

d. The employee is not a full time employee as defined by this regulation;

e. The employee has a dependent who was covered under the employee's employer-sponsored health benefit plan but that dependent is no longer eligible for such coverage, in which case an individual health benefit plan for such dependent may be marketed to the employee at the workplace;

f. The employee is a late enrollee who is completely excluded from his/her employer's health benefit plan for a year; or

g. The employee is in a waiting period for coverage under an employer-sponsored health benefit plan and all the following conditions are met:

(1) The individual health benefit plan marketed to such an employee is a short-term health benefit plan that can be rewritten by the short-term carrier or any other carrier for a combined total of no more than twelve (12) months; and

(2) The producer selling such a plan gives the employee an explanation of the employee's continuation rights under his/her prior employer's plan, if any.

K. Nothing in subsection J. above shall prohibit a small group carrier that provides coverage to a small employer group from offering individual health benefit plans to dependents of the eligible employees; however, the small employer carrier must also offer the group coverage to all of the dependents. Such group coverage could specify different levels of coverage for eligible employees and dependents.

Section 4 Definitions

A. "Actively marketed" means, for the purposes of this regulation, with respect to a small employer health benefit plan offered by a carrier, that the carrier uses at least the same sources and methods of distribution that it routinely uses in Colorado to market its most frequently sold small employer health benefit plan.

B. "Clear and conspicuous" means, for the purposes of this regulation, with respect to a disclosure, that the disclosure is reasonably understandable and designed to call attention to the nature and significance of the information it contains. A disclosure is considered designed to call attention to the nature and significance of the information in it if the carrier:

1. Uses a typeface and type size that are easy to read;

2. Provides wide margins and ample line spacing;

3. Uses boldface, italics, underscoring, or capitals for key words and phrases; and

4. In a form that combines the disclosure with other information, uses a plain-language heading to call attention to the disclosure portion of the document, and uses a type size that is greater than the type size predominantly used in the rest of the document.

C. "Case characteristics" shall have the same meaning as found at § 10-16-102(9), C.R.S.

D. "Creditable coverage" shall have the same meaning as found at § 10-16-102(16), C.R.S.

E. "Eligible employee" shall have the same meaning as found at § 10-16-102(18), C.R.S.

F. "Full time employee" means, for the purposes of this regulation, an employee that is reasonably expected to work at least a thirty (30) hour work week.

G. "Late enrollee" means, for the purposes of this regulation, an eligible employee or dependent that requests enrollment in a group health benefit plan after the initial enrollment period provided by the terms of the group health benefit plan, which must be no less than thirty (30) days, has passed.

H. "Limited benefit health insurance" means a health policy, contract or certificate issued, 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 catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan" as defined in § 10-16-102(32)(a), C.R.S.

I. "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 plan premiums or benefits 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.

J. "Small employer" shall have the same meaning as found at § 10-16-102(61), C.R.S., and includes partnerships that employ an average of at least one but not more than one hundred (100) eligible employees.

K. "Waiting period" means, for the purposes of this regulation, the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. Being "otherwise eligible to enroll" means that the employee has met the employer's eligibility conditions, specified in the plan's terms.

Section 5 Issuance of Coverage

A. Providing Coverage.

1. A small employer carrier shall actively offer to all small employers in the carrier's service area a choice of all small group plans the carrier markets in Colorado, as set forth in § 10-16-105, C.R.S. A small employer carrier shall issue coverage under any of its small group plans for which a small employer makes application.

a. A small employer carrier shall be considered to have met the requirement to offer its small group product at the time a policy has been issued. In the event that a small employer's coverage is terminated due to non-payment of premiums, the carrier that issued the policy can deny a new application for the same small employer on the basis of this termination, except that the application can be denied for six (6) months after termination for non-payment or at the end of the original policy period, whichever is greater.

This provision shall not relieve the employer of its responsibility for payment of any outstanding premiums or late charges owed for the prior period of coverage.

b. A small employer carrier shall be considered to have met the requirement to offer its small group product at the time a policy has been issued; therefore, a carrier does not have to honor requests to change policy provisions during the policy term.

2. A small employer carrier shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. For managed care plans, an employee must either work or reside in the carrier's service area to be considered an eligible employee, except as provided in § 10-16-704(2)(g), C.R.S.

3. A small employer carrier may offer the employees of a small employer the option of choosing among one or more health benefit plans, provided that each employee may choose any of the offered plans, except as provided in paragraph 4.A.5. of this Section. The choice among benefit plans may not be limited, restricted or conditioned based upon health status-related factors of the employees or their dependents. Nothing in this section limits the ability of a small employer carrier to set participation rules based upon group size that may limit the availability of multi-option plans to a single employer as long as any of the component plans offered could be accessed individually by any small employer.

4. A small employer carrier that only offers managed care plans may offer an indemnity plan to a small employer's out-of-area employees only (instead of to all employees). However, the following conditions may apply:

   a. A health maintenance organization (HMO) may offer coverage through an arrangement with an insurance carrier as long as the coverage is only made available to the out-of-area employees of a small employer. The use of insurance coverage for this purpose only will not result in the other carrier being considered a small employer carrier.

   b. An HMO may offer coverage to the out-of-area employees of a small employer or a small employer located outside of the HMO's approved service area pursuant to the notice, disclosure, and reimbursement provisions as described in § 10-16-704(2) and (2.5), C.R.S. If an HMO offers coverage to one or more out-of-area employees of a small employer or small employers, it must offer it to all small employers.

   c. A carrier offering a managed care plan may offer indemnity coverage as long as the coverage is only made available to the out-of-area employees of the small employer. For these plans, out-of-area employees are those working and residing outside of the state of Colorado.

   d. If a carrier offers indemnity out-of-area coverage to one or more small employers, it must offer it to all small employers.

5. Pursuant to § 10-16-107(5), C.R.S., a small employer carrier shall not vary the premium rate for a small employer health benefit plan by any factor other than the allowable case characteristics. Notwithstanding § 10-16-105.6(3) and (4), C.R.S., and subject to the provisions of the Affordable Care Act Section 2701, a small employer carrier is not permitted to impose a premium surcharge on a small employer when that small employer:

   a. Has at any time in the previous twelve (12) months purchased health coverage that is self-funded or insured through a non-small group health benefit plan; or

b. Has had its small group coverage discontinued because of non-payment of premium or fraud and is reapplying for coverage in the small group market.

6. A small employer carrier is not required to issue a small group policy to a small group partnership which does not meet its minimum participation requirements established pursuant to § 10-16-105(3), C.R.S.

B. Determining Who is an Eligible Employee and/or Dependent.

1. The Division finds that, when defining "eligible employee" in § 10-16-102(18), C.R.S., the sole intent of the General Assembly was to create a maximum weekly work requirement which small employer carriers may impose as a requirement for an employee's participation in a health benefit plan. Nothing in the definition of "eligible employee" was intended to limit an employer's traditional ability to set valid and acceptable standards for employee eligibility based upon the terms and conditions of employment, including a minimum weekly work requirement in excess of thirty (30) hours and eligibility based upon salaried versus hourly workers and management versus non-management employees.

2. The Division finds that, subject to other statutory restrictions and the provisions of this regulation, a small employer carrier may offer a health benefit plan to the eligible employees of a small employer as that employer defines its eligible employees (herein after referred to as "employer-determined eligible employees"). However, a carrier must offer coverage to all small employers for all employees with a regular work week of at least thirty (30) hours on a regular basis. The decision of a small employer to limit eligibility for coverage as provided for in paragraph 1. of this subsection B. shall be solely at the small employer's discretion, without direct or indirect pressure or suggestion by the carrier, producer, or their representatives. The small employer carrier may offer coverage only to such employer-determined eligible employees and their dependents and may apply its minimum participation and contribution criteria solely to such employer-determined eligible employees.

3. Listing of eligible employees and dependents.

a. A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list.

b. The small employer carrier may require the small employer to provide appropriate supporting documentation, such as the Unemployment Insurance Quarterly Wage and Tax Report (UITR) often referred to as a W-2 Summary Wage and Tax Form, to verify the information required under this paragraph.

c. In the event that a UITR form is not available because the employer was not in business during the preceding quarter or the employer has outsourced payroll functions or this form is not required due to federal tax exemptions related to the type of small business or not available due to the business form, the carrier shall accept reasonable alternate documentation for this information. Alternate documentation includes, but is not limited to, payroll documentation from the employer or the employer's payroll administrator or employee leasing company; organizational documents; or other reasonable proof.

4. Waivers.

a. A small employer carrier must secure a waiver with respect to each eligible employee and each dependent of such an eligible employee (or each employer-determined eligible employee and their dependents if this is different than the list of eligible employees) who declines an offer of coverage under a health benefit plan provided to a small employer.

b. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan.

c. The waiver form shall require that the reason for declining coverage (e.g., covered under another plan, cannot afford coverage, etc.) be stated on the form.

d. Waiver forms shall be maintained by the small employer carrier.

C. Waiting periods are permissible as long as they do not exceed ninety (90) days.

Section 6 Restrictive Riders

A. Small employer carriers shall not place restrictive riders, endorsements or other policy provisions on a small group plan that would restrict coverage of particular individuals. If a small employer carrier offers coverage to a small employer, such carrier shall offer the coverage under terms and conditions that are consistent with Colorado law to all eligible employees of the small employer and their dependents.

B. A small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions or services otherwise covered by the plan.

Section 7 Rules Related to Fair Marketing

A. A small employer carrier shall actively market each of its health benefit plans to Colorado small employers in all areas where the carrier is authorized to conduct business.

B. Every health benefit plan offered by a small employer carrier to new groups with less than one hundred and one (101) eligible employees shall be actively marketed to all groups that meet the definition of a small employer pursuant to § 10-16-102(61), C.R.S. Managed care plans are required to maintain an adequate network pursuant to § 10-16-704(1), C.R.S., and must have a participating provider for all covered benefits.

1. HMOs are authorized to conduct business in the specific counties and/or zip codes approved by the Division.

2. A carrier offering a managed care plan that is not an HMO or HMO Point-of-Service (POS) plan must actively market its small group plans across the service area, which is defined as the entire state of Colorado.

3. Carriers that are not able to maintain a sufficient network after good-faith efforts to contract may employ certain remedies as described in § 10-16-704(2) and (2.5), C.R.S.

C. Small employer carriers cannot deny an application for coverage from a group based on its size, if the group satisfies the definition of a small employer unless, pursuant to Section 3 of this regulation, such small employer group is not subject to the provisions of this regulation.

D. Small employer carriers may establish participation rules that vary based upon group size as allowed in § 10-16-105(3)(c), C.R.S.; however, the required participation level shall not exceed 70% of eligible employees who are not covered by existing group or individual creditable coverage that was legally obtained prior to the individual's eligibility for group coverage under the employer's existing group plan and consistently maintained by the individual.

E. Carriers must apply application cut-off dates consistently to all small group employer applicants. Under no circumstance shall the application cut-off date be earlier than the first of the month prior to the requested effective date of coverage.

F. Price Quotes.

1. A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within five (5) business days of receiving all information necessary to provide a requested quote. Each price quote must be calculated using the carrier's filed rate, as defined in Colorado Insurance Regulation 4-2-39.

2. A small employer carrier shall notify a small employer (directly or through an authorized producer) within five (5) business days of receiving a request for a price quote if any additional information is needed. If a small employer carrier provides a price quote prior to receiving all information necessary to calculate any premium adjustments allowed under § 10-16-107(5), C.R.S., that quote must be of the filed rate. The quote shall include a statement indicating that the rate is not final, and once all information is received, the rate will be recalculated using rating factors allowable by law, and may vary from the initial price quote.

3. A price quote shall be provided without requiring verification of the eligibility of the small group. The fact that a price quote has been issued shall not prevent the small employer carrier from verifying the group's eligibility before issuing the coverage.

G. A small employer carrier shall not establish small group producer commission or bonus programs in a manner that discourages marketing to very small groups. A commission or bonus program that establishes a lower payment rate such as a lower flat fee per employee or member or percentage of premiums for smaller employers based upon a group's size shall be considered risk avoidance and an unfair trade practice.

H. No producer or carrier shall advise, induce or encourage a small employer to arrange for coverage for an employee or dependent through another policy for the purposes of separating such person from the group policy, except as allowed under subsection 3.K. of this regulation.

I. A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or other such information that is reasonably designed to assist the caller to locate an authorized producer or otherwise apply for coverage through the carrier.

J. A small employer carrier shall conform to the renewability requirements specified in § 10-16-105.1, C.R.S.

K. Small employer carriers shall elicit, at the time of application, information from applicants necessary to determine whether or not small group laws apply pursuant to § 10-16-105.2, C.R.S. If a small employer carrier fails to elicit this information, it shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had done so.

Section 8 Disclosure Requirements

A. Pursuant to § § 10-16-107(5)(f) and 10-16-704(9), C.R.S., small employer carriers shall provide a disclosure in all small employer marketing and solicitation materials, in a clear and conspicuous manner, that:

1. Specifies that the employer will not be considered part of a separate class of business;

2. Specifies all factors, including case characteristics, utilized in setting premium rates for a specific employer;

3. Explains the employer's right to renew;

4. Discloses that rates for any and all small group products being marketed by the carrier in the Colorado small group market will be given to a small employer, upon either oral or written request of such employer, within five (5) business days of the request; and

5. In the case of a managed care plan, explains the existence, availability and general nature of an access plan (e.g., that an access plan exists for every managed care plan and that it lists hospitals, providers, referral procedures, grievance procedures and emergency coverage provisions).

B. Pursuant to § 10-16-107(5)(f), C.R.S., small employer carriers shall also include in all printed marketing and solicitation materials information as to the benefits and premiums available under all health benefit plans for which the employer is qualified. This requirement shall be satisfied if the carrier provides the following information:

1. The policy number (if any), policy name and policy type (e.g., HMO, indemnity, preferred provider, point-of-service plan) for all the plans for which the employer qualifies; and

2. A summary of the benefits available under all the plans for which the employer qualifies that highlights the most salient differences among the plans as required in Colorado Insurance Regulation 4-2-20.

Section 9 Notice of Intent to Participate as a Small Employer Carrier

A carrier shall not offer health benefit plans to small employers in this state, unless the carrier has filed with the Commissioner a notice of intent to operate as a small employer carrier.

Section 10 Severability

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

Section 11 Enforcement

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

Section 12 Effective Date

This amended regulation will be effective as of January 1, 2016.

Section 14 History

Originally issued as Emergency Regulation 94-E-5, effective October 20, 1994.
Reissued as Emergency Regulation 95-E-3, effective January 20, 1995.
Issued as Regulation 4-6-8, effective March 1, 1995.
Amended sections 1, 2, 4, 9, and 15 of Regulation 4-6-8, effective December 31, 1995.
Amended sections 1 through 12 and 15 of Regulation 4-6-8, effective November 1, 1997.
Amended Regulation 4-6-8, effective March 2, 2003.
Amended Regulation 4-6-8 effective October 1, 2004.
Amended Regulation 4-6-8 effective October 1, 2009.
Amended Regulation effective June 1, 2011.
Amended Regulation effective January 1, 2012.
Amended Regulation effective October 15, 2013.
Amended Regulation effective January 1, 2016.

Regulation 4-6-9 CONCERNING CONVERSION COVERAGE [Repealed eff. 11/01/2013]

Regulation 4-6-10 EMPLOYEE LEASING COMPANIES AND HEALTH CARE COVERAGE

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this regulation is to establish and implement rules for health carriers that issue and renew health plans to employee leasing companies and work-site employers.

Section 3 Applicability

This regulation shall apply to all health carriers.

Section 4 Definitions

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

B. "Employee leasing company" shall have the same meaning as set forth in § 8-70-114(2)(a)(V), C.R.S.

C. "Employee leasing company contract" shall have the same meaning as set forth in § 8-70-114(2)(a)(VI), C.R.S.

D. "Work-site employer" shall have the same meaning as set forth in § 8-70-114(2)(a)(VII), C.R.S.

Section 5 Rules

A. Carriers shall ensure that health plans issued or renewed to employee leasing companies that have aggregated their work-site employers for purposes of sponsoring health coverage as permitted by § 8-70-114(2)(a)(VIII), C.R.S., conform with all laws applicable to large group health coverage products, where the total aggregated employees exceeds fifty.

B. Carriers shall issue or renew group health coverage directly to work-site employers, where the work-site employer meets the definition of a small group as required by law, where the employee leasing company does not sponsor a health plan for its work-site employers.

1. If the employee leasing company does not provide access to a group plan to work-site employers, then providing only administrative functions related to health coverage does not constitute "sponsoring" a health coverage plan. An employee leasing company shall not be considered to be sponsoring a health coverage plan where the employee leasing company performs only administrative functions related to health coverage purchased directly by work-site employers. Examples of administrative functions include, but are not limited to deducting premiums from work-site employer payrolls for delivery to the carrier; and administering premium collection for COBRA continuation coverage.

2. Employee leasing companies shall not be considered to be sponsoring a health coverage plan under subsection B where the employee leasing company provides health coverage solely for its own staff who are separate and distinct from the work-site employer employees.

C. Carriers may issue or renew health plans directly to work-site employers where the employee leasing company has aggregated work-site employees for purposes of sponsoring health coverage, but the work-site employer has declined the coverage, provided the employee leasing company offers to sponsor health coverage for the work-site employer at the time of initial contracting with the work-site employer and at least at each open enrollment period, and the carrier obtains access to the certification specified below.

1. An employee leasing company is sponsoring a health coverage plan where the employee leasing company is directly involved in the negotiation or procurement of the health plan for the work-site employers. An example of involvement in the negotiation or procurement of the health plan includes, but is not limited to instances where the employee leasing company requires the work-site employer to use a particular producer or carrier in order to obtain particular services or benefits through the employee leasing company.

2. The carrier providing the employee leasing company sponsored coverage shall retain access to the certification required pursuant to paragraphs (e) and (f) of § 8-70-114(2), C.R.S. The carrier shall make this certification available within a reasonable time upon request by the Commissioner.

D. Carriers may offer health coverage to the employee leasing company's administrative staff separately from the coverage offered to the employees of the work-site employer, even where the employee leasing company aggregates work-site employer employees under § 8-70-114(2)(b)(VIII), C.R.S. The carrier may consider only the number of employee leasing company administrative employees for purposes of determining the applicability of small group or large group laws applicable to the particular plan offered to the employee leasing company's administrative employees.

E. Carriers providing employee leasing company sponsored health plans may require the employee leasing company to apply the carrier's contribution and participation requirements to discrete potential work-site employer groups prior to contracting, where:

1. The participation and contribution requirements are in writing and are developed by the carrier and not by the employee leasing company;

2. The participation and contribution requirements are the same for all potential work-site employers of that employee leasing company; and

3. The participation and contribution requirements are applied uniformly and in a non-discriminatory fashion to all potential work-site employers by the employee leasing company.

Section 6 Severability

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

Section 7 Enforcement

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

Section 8 Effective Date

This amended regulation is effective January 1, 2014.

Section 9 History

New regulation, effective June 1, 2001.
Amended regulation, repealing section 5.E. and reformatting, effective March 31, 2003.
Amended regulation effective July 15, 2011.
Amended regulation effective January 1, 2014.

Regulation 4-6-11 CONCERNING COVERCOLORADO STANDARDIZED NOTICE FORM TO BE USED TO NOTIFY CERTAIN INDIVIDUALS, ELIGIBLE FOR MEDICARE, OF ELIGIBLITY FOR COVERCOLORADO [Repealed eff. 01/01/2014]

Regulation 4-6-12 MANDATORY COVERAGE OF MENTAL ILLNESSES FOR SMALL GROUP GRANDFATHERED 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 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to clarify the coordination of subsections (5) and (5.5) of § 10-16-104, C.R.S. (2012), concerning mental illness and biologically based mental illness (BBMI).

Section 3 Applicability

This regulation applies to every carrier which has small group grandfathered health benefit plans pursuant to § 10-16-105, C.R.S. (2012).

Section 4 Definitions

A. "Biologically based mental illness" (BBMI) shall have the same meaning as found at § 10-16-104(5.5), C.R.S.

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

C. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.

Section 5 Rules

A. Section 10-16-104(5), C.R.S. (2012) applies to grandfathered small group policies as defined in § 10-16-102(42), C.R.S. (2012).

B. Section 10-16-104(5), C.R.S. (2012), applies to all mental illness conditions including but not limited to the BBMI benefits required by § 10-16-104(5.5), C.R.S. (2012), under grandfathered small group health benefit plans and includes the following mandated benefits:

1. At least 45 inpatient (90 partial hospitalization) days in any one twelve-month period;

2. No less than 20 outpatient visits or no less than $1,000 paid for outpatient visits in any twelve-month period; and

3. Copayment or coinsurance shall not exceed a 50% requirement.

C. Section 10-16-104(5.5), C.R.S. (2012), applies to a defined subset of mental illness conditions for BBMI for grandfathered small group health benefit plans. Section 10-16-104(5.5), C.R.S. (2012), provides coverage for treatment for BBMI that is no less extensive than coverage provided for any other physical illness.

D. Based on subsections B. and C. of this section 5, the following findings are made:

1. The increased insurance coverage of § 10-16-104(5.5) C.R.S. (2012), for BBMI was not intended to duplicate coverage provided in § 10-16-104(5), C.R.S. (2012), or provide a double benefit;

2. Treatment for BBMI under § 10-16-104(5.5), C.R.S. (2012), might permit "different" types of treatment than would be permitted under subsection § 10-16-104(5), C.R.S. (2012), but will provide "additional" insurance benefits above the limitations set out in subsection § 10-16-104(5), C.R.S. (2012).

3. BBMI benefits provided in accordance with § 10-16-104(5.5), C.R.S. (2012), reduce or exhaust the benefits mandated by § 10-16-104(5), C.R.S. (2012).

4. BBMI benefits provided in accordance with § 10-16-104(5.5), C.R.S. (2012), must be provided at the more generous of the physical illness or mental illness benefits of § 10-16-104(5), C.R.S. (2012), through the 20th visit. Thereafter, the copayment or coinsurance protections continue to apply to BBMI pursuant to § 10-16-104(5.5), C.R.S. (2012).

E. Utilization review mechanisms used to make a determination to provide coverage for biologically based mental illness will not be more restrictive than that used in the determination to provide coverage for any other physical illness.

Section 6 Severability

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

Section 7 Enforcement

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

Section 8 Effective Date

This regulation shall become effective on January 15, 2014.

Section 9 History

Emergency Regulation 08-E-2 effective January 1, 2008.
New Regulation effective February 1, 2008.
Emergency Regulation 09-E-02 effective July 1, 2009.
Amended Regulation effective November 1, 2009.
Amended Regulation effective January 15, 2014.

Regulation 4-6-13 QUARTERLY RATE FILING REQUIREMENTS FOR SMALL GROUP HEALTH BENEFIT PLANS

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules concerning the quarterly filing of rates for small group health benefit plans.

Section 3 Applicability

This regulation applies to all carriers offering small group health benefit plans subject to the small group laws of Colorado. This regulation does not apply to grandfathered small group health benefit plans.

Section 4 Definitions

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

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

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

D. "Off-cycle" means, for the purposes of this regulation, the quarterly filing of small group health benefit plans that do not coincide with the annual rate and form filing dates for small group health benefit plans. Small group health benefit plans filed for effective dates other than January 1 are considered off-cycle filings.

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

F. "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 small group health benefit plans must be filed with the Division.

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

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

Section 5 Rules

A. For plans to be issued or renewed on or after October 1, 2014, carriers offering small group health benefit plans may file rates for those plans no more frequently than quarterly.

B. Quarterly rate filings for existing small group health benefit plans may include:

1. Changes to the index rate;

2. Changes to the quarterly trend;

3. Changes to the premium base rate; and

4. Changes to the allowed rating factors.

C. New small group health benefit plans filed off-cycle.

1. Notwithstanding the requirements of other Colorado Insurance Regulations, if a carrier files a new small group health benefit plan as a quarterly rate filing that was not filed as a new product during the annual individual and small group filing cycle, when selling that plan:

a. The carrier shall not impose any minimum group participation requirements; and

b. The carrier shall not impose any minimum employer contribution requirements.

2. If a carrier files a new small group health benefit plan as a quarterly rate filing that was not filed as a new product during the annual individual and small group filing cycle, that plan must comply with the form filing requirements found in Colorado Insurance Regulation 4-2-41.

3. If a carrier files a new small group health benefit plan during the annual small group filing cycle, when selling that plan the carrier may impose:

a. Minimum group participation requirements; and

b. Minimum employer contribution requirements.

D. Carriers must submit all quarterly rate filings through SERFF.

E. A small group health benefit plan that has been filed as a new plan shall only become effective upon the first day of a quarter: January 1; April 1; July 1; or October 1.

F. Carriers must comply with all rate filing requirements found in Colorado Insurance Regulation 4-2-39.

G. Carriers must submit quarterly rate filings such that each filing complies with the timetables for quarterly rate submissions, both for new and existing plans, and to provide sufficient time for plan validation processes through SERFF. Quarterly rate filings must be filed with the Division at least sixty (60) days prior to the proposed implementation or effective date specified in the rate filing. Additionally, if there is a filing timeframe due to federal requirements, such as a Health Insurance Oversight System (HIOS) filing, carriers must comply with the federal filing requirements, due to the nature of dual state and federal rate review.

H. Index rate: Each carrier offering a health benefit plan to small employers in Colorado shall develop a single index rate for all small group plans it offers. It should be calculated using the experience for all small group plans. The premium rate charged during a rating period, applicable to all small employers, shall be based upon this index rate, adjusted for case characteristics and coverage. Quarterly rate filings must comply with the single index rate.

I. Carriers making quarterly rate filings which modify plans or issue new plans will need to submit a compliant binder filing, form filing, network adequacy filing and if applicable reasonable modification filing through SERFF.

Section 6 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 7 Enforcement

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

Section 8 Effective Date

This regulation shall become effective on March 15, 2015.

Section 9 History

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

Editor's Notes

3 CCR 702-4 has been divided into smaller sections for ease of use. Versions prior to 09/01/2011 and rule history are located in the first section, 3 CCR 702-4. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective after 09/01/2011, select the desired part of the rule, for example 3 CCR 702-4 Series 4-1, or 3 CCR 702-4 Series 4-6.

History

[For history of this section, see Editor's Notes in the first section, 3 CCR 702-4]