

## DEPARTMENT OF REGULATORY AGENCIES

### Division of Insurance

#### LIFE, ACCIDENT AND HEALTH, Series 4-2

#### 3 CCR 702-4 Series 4-2

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

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

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History
Appendix A	Notice of Replacement
Appendix B	Notice of Replacement (Non-health Benefit Plans)
Appendix C	Notice of Replacement (Health Benefit Plans)

#### Section 1      Authority

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

#### Section 2      Scope and Purpose

The purpose of this regulation is to reduce the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance. The scope of this regulation includes persons covered by an individual health care coverage plan offered by a health maintenance organization and individual accident and sickness insurance policies or plans, who are considering replacement of their coverage.

#### Section 3      Applicability

This regulation shall apply to individual accident and sickness insurance policies and all service or indemnity contracts offered by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 (except Medicare supplement insurance, conversion to an individual or family policy from a group, blanket or group type policy, or any other insurance that is covered by a separate state statute).

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**Section 4        Definitions**

- A.        “Accident and sickness insurance” means a policy, plan, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits or medical, surgical or hospital benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts. An accident and sickness insurance policy does not include a Medicare supplement insurance policy, or any other type of accident and sickness insurance with advertising guidelines covered by a separate statute. For the purposes of this regulation, accident and sickness insurance includes health coverage plans issued by carriers as defined in § 10-16-102(8), C.R.S.
- B        “Direct response” means a solicitation through a sponsoring or endorsing entity or individually solely through mail, telephone, the Internet or other mass communication media.

**Section 5        Rules**

- A.        Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has accident and sickness insurance in force, or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.
1.        Statements
- a.        You normally do not require more than one of the same type of policy.
- b.        If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- c.        You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.
- d.        If you are eligible for Medicare due to age or disability, counseling services are available in Colorado to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.
2.        Questions
- To the best of your knowledge:
- a.        Do you have another insurance policy or contract in force?
- (1)        If so, with which company?
- (2)        If so, do you intend to replace your current accident and sickness insurance with this policy (contract)?
- b.        Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy?
- (1)        If so, with which company?

- (2) What kind of policy?
  - c. Are you covered for medical assistance through the state Medicaid program:
    - (1) As a Specified Low-Income Medicare Beneficiary (SLMB)?
    - (2) As a Qualified Medicare Beneficiary (QMB)?
    - (3) For other Medicaid medical benefits?
- B. Producers must list any other accident and sickness insurance they have sold to the applicant.
  - 1. List policies sold which are still in force; and
  - 2. List policies sold in the past five (5) years which are no longer in force.
- C. In the case of a direct response carrier, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the carrier, shall be returned to the applicant by the carrier upon delivery of the policy.
- D. Upon determining that a sale will involve replacement of accident and sickness insurance, a carrier, other than a direct response carrier, or its producer, shall furnish the applicant, prior to issuance or delivery of the accident and sickness insurance policy or contract, a notice regarding replacement of accident and sickness insurance. One (1) copy of such notice signed by the applicant and producer, except where the coverage is sold without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the carrier. A direct response carrier shall deliver to the applicant, at the time of issuance of the policy, the appropriate notice, located in Appendix A, B or C of this regulation.
- E. The notice contained in Appendix A shall be used through December 31, 2013. The notices contained in Appendix B and C shall be used on or after January 1, 2014.
- F. The notices required by Subsection D above for a carrier, must be provided in the format prescribed and adopted by the Commissioner of Insurance.
- G. Paragraphs 1 and 2, contained in Appendix A, may be deleted by the carrier if the replacement does not involve the application of a new preexisting condition limitation.
- H. Paragraph 1 in Appendix B, may be deleted by the carrier if the replacement does not involve the application of a new preexisting condition limitation.
- I. Failure to comply with the requirements of this Section 5 constitutes an unfair method of competition and an unfair or deceptive act or practice in the business of insurance which is prohibited under § 10-3-1104, C.R.S.

## **Section 6 Severability**

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

**Section 7      Enforcement**

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

**Section 8      Effective Date**

This regulation is effective November 1, 2013.

**Section 9      History**

Originally issued as Regulation 74-2, effective March 15, 1974.  
Amended December 22, 1975, effective January 1, 1976.  
Amended effective January 14, 1977.  
Amended effective January 14, 1977.  
Renumbered on June 1, 1992.  
Repealed and Repromulgated in full, effective February 1, 2001.  
Amended Regulation 4-2-1, effective May 1, 2010.  
Amended Regulation effective November 1, 2013.

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

**[Insurance Carrier name and address]**

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by [Insurance Carrier Name]. Your new policy will provide [Number days of free look period, if any] days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:**

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

- ☐ Additional benefits
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other. (please specify)

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or contract is guaranteed issued this paragraph need not appear].

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

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(Signature of Producer or Other Representative)\*

[Typed Name and Address of Issuer or Producer]

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(Applicants Signature)

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(Date)

\*Signature not required for direct response sales.

## **Appendix B NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

### **[Insurance Carrier Name and Address]**

According to [your application] [the information furnished by you], you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by [insurance carrier name]. Your new policy will provide [number days of free look period, if any] days within which you may decide without cost whether you want to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

### **STATEMENT TO APPLICANT BY CARRIER OR PRODUCER:**

I have reviewed your current health coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

- \_\_\_\_\_ Additional benefits
- \_\_\_\_\_ No change in benefits, but lower premiums
- \_\_\_\_\_ Fewer benefits and lower premiums
- \_\_\_\_\_ Other. (please specify)

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or contract is guaranteed issued this paragraph need not appear].

Do not cancel your current policy until you have received your new policy and are sure that you want to keep it.

\_\_\_\_\_  
(Signature of Producer or Other Representative)\*

[Typed Name and Address of Carrier or Producer]

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

**Appendix C NOTICE TO APPLICANT REGARDING REPLACEMENT OF A HEALTH BENEFIT PLAN**

**[Insurance Carrier Name and Address]**

According to [your application] [the information furnished by you], you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by [insurance carrier name]. Your new policy will provide [number days of free look period, if any] days within which you may decide without cost whether you want to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY CARRIER OR PRODUCER:**

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

- ☐ Additional benefits
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other. (please specify)

Do not cancel your current policy until you have received your new policy and are sure that you want to keep it.

\_\_\_\_\_  
(Signature of Producer or Other Representative)\*

[Typed Name and Address of Carrier or Producer]

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

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

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

**Section 1      Authority**

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

**Section 2      Scope and Purpose**

This regulation prohibits insurers from refusing to pay benefits under certain contracts because of hospitalization in government hospitals.

### **Section 3      Applicability**

This regulation applies to all hospital indemnity and disability income policies, contracts, riders, endorsements, etc., which provide benefits because of hospitalization or disability originating out of hospitalization hereinafter referred to as hospital indemnity and disability income policies. It does not apply to hospital expense policies.

### **Section 4      Definitions**

For the purposes of this regulation:

- A.      “Disability income policy” means, for the purposes of this regulation, a policy that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury.
- B.      “Government hospital” means, for the purposes of this regulation, any hospital under governmental control whether federal, state, county or city. It includes Veterans Administration hospitals.
- C.      “Hospital indemnity policy” means, for the purposes of this regulation, a policy that provides a stated daily, weekly or monthly payment while the insured is hospitalized, regardless of expenses incurred and regardless of whether or not other insurance is in force. The insured can use the daily, weekly or monthly benefit as he or she chooses, for hospital or other expenses.

### **Section 5      Rules**

All hospital indemnity and disability income policies delivered or issued for delivery in the State of Colorado which provide benefits predicated on hospitalization will not in any way deny such benefits on the basis that such hospitalization was in a government hospital.

### **Section 6      Severability**

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

### **Section 7      Enforcement**

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

### **Section 8      Effective Date**

This regulation shall be effective December 1, 2013.

### **Section 9      History**

Originally issued as Regulation 74-4, effective July 1, 1974.  
Renumbered as Regulation 4-2-2, effective June 1, 1992.  
Repealed and Repromulgated in full, effective January 1, 2001.  
Amended Regulation 4-2-2, effective July 1, 2010.  
Amended Regulation 4-2-2, effective December 1, 2013.



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

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Method of Disclosure of Required Information
Section 6	Form and Content of Advertisements
Section 7	Advertisement of Benefits Payable, Losses Covered or Premiums Payable
Section 8	Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination
Section 9	Standards for Marketing
Section 10	Testimonials or Endorsements by Third Parties
Section 11	Use of Statistics
Section 12	Identification of Plan or Number of Policies
Section 13	Disparaging Comparisons and Statements
Section 14	Jurisdictional Licensing and Status of Insurer
Section 15	Identity of Insurer
Section 16	Group or Quasi-Group Implications
Section 17	Introductory, Initial or Special Offers
Section 18	Statements about an Insurer
Section 19	Filing Requirements
Section 20	Enforcement Procedures
Section 21	Severability
Section 22	Incorporated Materials
Section 23	Enforcement
Section 24	Effective Date
Section 25	History
Appendix A	Marketing Filing Procedures

**Section 1            Authority**

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

**Section 2            Scope and Purpose**

The purpose of this regulation is to establish minimum criteria to assure proper and accurate description and to protect prospective purchasers with respect to the advertisement of accident and sickness insurance in the same manner as the regulation governing advertisements of Medicare supplement insurance. This regulation assures the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as accident and sickness insurance by the establishment of standards of conduct in the advertising of accident and sickness insurance in a manner that prevents unfair, deceptive and misleading advertising and is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance producers and companies.

**Section 3            Applicability**

- A.        This regulation shall apply to any accident and sickness insurance “advertisement,” as that term is defined, intended for presentation, distribution or dissemination in this State when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, producer or solicitor, as those terms are defined in the Insurance Code of this state and this regulation.

- B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All of the insurer's advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are advertised.
- C. Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

#### **Section 4 Definitions**

- A. "Accident and sickness insurance policy" means, for the purposes of this regulation, a policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits or medical, surgical or hospital benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts.
  - 1. An accident and sickness insurance policy does not include a Medicare supplement insurance policy or any other type of accident and sickness insurance with advertising guidelines covered by a separate statute and/or regulation.
  - 2. The language "except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts" means it does not include disability, waiver of premium and double indemnity benefits included in life insurance, endowment or annuity contracts or contracts supplemental to the above contracts that contain only provisions that:
    - a. Provide additional benefits in case of death or dismemberment or loss of sight by accident; or
    - b. Operate to safeguard the contracts against lapse or to give a special surrender value, special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled as defined by the contract or supplemental contract.
- B. "Advertisement" means, for the purposes of this regulation, printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other Internet displays or communications, other forms of electronic communications, billboards and similar displays.
  - 1. "Advertisement" also contains;
    - a. Descriptive literature and sales aids of all kinds issued by an insurer, producer, or solicitor for presentation to members of the insurance-buying public, such as circulars, leaflets, booklets, depictions, illustrations, form letters and lead-generating devices of all kinds;
    - b. Prepared sales talks, presentations and material for use by producers and solicitors whether prepared by the insurer, producer or solicitor;
    - c. Summary of Benefits and Coverage (SBC) forms; and
    - d. The Colorado Supplement to the Summary of Benefits and Coverage Form as found in Colorado Insurance Regulation 4-2-20.

2. The definition of “advertisement” includes advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.
  3. The definition of “advertisement” extends to the use of all media for communications to the general public, to the use of all media for communications to specific members of the general public, and to the use of all media for communications by insurers, producers and solicitors.
  4. The definition of “advertisement” does not include:
    - a. Material used solely for the training and education of an insurer’s employees or producers;
    - b. Material used in-house by insurers;
    - c. Communications within an insurer’s own organization not intended for dissemination to the public;
    - d. Individual communications of a personal nature with current policyholders other than material urging the policyholders to increase or expand coverages;
    - e. Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;
    - f. Court-approved material ordered by a court to be disseminated to policyholders; or
    - g. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged; provided that the announcement clearly indicates that it is preliminary to the issuance of a booklet and that the announcement does not describe the specific benefits under the contract or program nor describe advantages as to the purchase of the contract or program. This does not prohibit a general endorsement of the program by the sponsor.
- C. “Certificate” means, for the purposes of this regulation, a statement of the coverage and provisions of a group accident and sickness insurance policy, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.
- D. “Exception” means, for the purposes of this regulation, any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.
- E. “Health benefit plan” shall have the same meaning as defined in § 10-16-102(32), C.R.S.
- F. “Institutional advertisement” means, for the purposes of this regulation, an advertisement having as its sole purpose the promotion of the reader’s, viewer’s or listener’s interest in the concept of accident and sickness insurance, or the promotion of the insurer as a seller of accident and sickness insurance. Carriers are required to comply with section 15.A. of the regulation, clearly identifying the name of the carrier.
- G. “Insurer” shall have the same meaning as “carrier” as defined in § 10-16-102(8), C.R.S., and applies to any insurer subject to Title 10, Article 16, Parts 2, 3 or 4.

- H. "Invitation to contract" means, for the purposes of this regulation, an advertisement that is neither an "invitation to inquire" nor an "institutional advertisement".
- I. "Invitation to inquire" means, for the purposes of this regulation, an advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss for which benefits are payable, but may contain the dollar amount of benefits payable and the period of time during which benefits are payable.
1. An "invitation to inquire" may not refer to cost.
2. An "invitation to inquire" shall contain a provision in the following or substantially similar form:
- "This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance producer or the company [whichever is applicable]."
- J. "Lead-generating device" means, for the purposes of this regulation, any communication directed to the public that, regardless of form, content or stated purpose is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of accident and sickness insurance.
- K. "Limitation" means, for the purposes of this regulation, a provision that restricts coverage under the policy other than an exception or a reduction.
- L. "Limited benefit health coverage" means, for the purposes of this regulation, a health policy, contract, or certificate offered or marketed as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments, or coinsurance amounts not covered by a health benefit plan. "Limited benefit health coverage" does not include short-term hospital and medical expense policies, contracts or certificates, or catastrophic health policies, contracts, or certificates. Such non-supplemental plans are included under the term "health benefit plan" as defined in § 10-16-102(32), C.R.S.
- This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance.
- M. "Marketing" means, for the purposes of this regulation, any activity or effort directed toward the public which is intended to promote or sell products or services.
- N. "Patient Protection and Affordable Care Act" and "ACA" mean, for the purposes of this regulation, the Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.
- O. "Prominently" or "conspicuously" means, for the purposes of this regulation, that the information to be disclosed "prominently" or "conspicuously" will be presented in a manner that is noticeably set apart from other information or images in the advertisement.
- P. "Reduction" means, for the purposes of this regulation, a provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable had the reduction not been used.
- Q. "SERFF" means, for the purposes of this regulation, System for Electronic Rate and Form Filings.

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

## **Section 5 Method of Disclosure of Required Information**

All information, exceptions, limitations, reductions and other restrictions required to be disclosed by this regulation shall be set out conspicuously and in close conjunction to the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading. This regulation permits, but is not limited to, the use of either of the following methods of disclosure:

- A. Disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of policy benefits; or
- B. Disclosure not in conjunction with the provisions describing policy benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure or otherwise made to appear unimportant. The phrase "under appropriate captions" means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: "Exceptions", "Exclusions", "Conditions Not Covered", and "Exceptions and Reductions". The use of captions such as the following are prohibited because they do not provide adequate notice of the significance of the material: "Extent of Coverage", "Only these Exclusions", or "Minimum Limitations".

## **Section 6 Format and Content of Advertisements**

- A. The format and content of an advertisement of an accident and sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Format means the arrangement of the text and the captions.
- B. Distinctly different advertisements are required for publication in different media, such as newspapers or magazines of general circulation as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this regulation.
- C. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed.
- D. Advertisements shall be truthful and not misleading in fact or implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.
- E. An insurer shall clearly identify its accident and sickness insurance policy as an insurance policy. A policy trade name shall be followed by the words "insurance policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

- F. An insurer, producer, solicitor or other person shall not solicit a resident of this state for the purchase of accident and sickness insurance in connection with or as the result of the use of advertisement by the person or any other persons, where the advertisement:
1. Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or
  2. Otherwise violates the provisions of this regulation.
- G. An insurer, producer, solicitor or other person shall not solicit residents of this state for the purchase of accident and sickness insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character or proprietary or representative capacity of the person or the true purpose of the advertisement.
- H. An insurer is prohibited from representing or naming any health coverage plan as a Bronze, Silver, Gold, or Platinum metal tier level of coverage unless that policy is a health benefit plan as specified in § 10-16-103.4, C.R.S. Use of these terms for a non-ACA compliant health coverage plan may be found to violate § 10-3-1104(1)(a)(V), C.R.S.

**Section 7      Advertisements of Benefits Payable, Losses Covered or Premiums Payable**

- A. Covered Benefits.
1. The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited.
  2. An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited.
  3. An advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of information or use of words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.
  4. An advertisement shall not contain or use words or phrases such as "all", "full", "complete", "comprehensive", "unlimited", "up to", "as high as", "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "the policy will help to replace your income" (when used to express loss of time benefits), or similar words and phrases, in a manner that exaggerates a benefit beyond the terms of the policy.
  5. An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholder is prohibited unless, in making the reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility if an assignment of benefits is made by the policyholder. An advertisement of medical and surgical expense benefits shall comply with this regulation in regard to the disclosure of assignments of benefits to providers of services. Phrases such as "you collect", "you get paid", "pays you", or other words or phrases of similar import may be used so long as the advertisement indicates that it is payable to the insured or someone designated by the insured.

6. An advertisement for basic hospital expense coverage, basic medical-surgical expense coverage, basic hospital/medical-surgical expense coverage, hospital confinement indemnity coverage, accident only coverage, specified disease coverage, specified accident coverage or limited benefit health coverage or for coverage that covers only a certain type of loss is prohibited if:
  - a. The advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without, also in the same headline, a lead-in or caption specifying the applicable daily limits and other internal limits;
  - b. The advertisement states a total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit; or
  - c. The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim.

This paragraph 6. does not apply to individual health benefit plans, individual basic medical expense coverage, or disability income insurance.

7. Advertisements that emphasize total amounts payable under hospital, medical or surgical accident and sickness insurance coverage or other benefits in a policy, such as benefits for private duty nursing, are prohibited unless the actual amounts payable per day for the indemnity or benefits are stated.
8. Advertisements that include examples of benefits payable under a policy shall not use examples in a way that implies that the maximum benefit payable under the policy will be paid, when less than maximum benefits are paid for an average claim.
9. When a range of benefit levels is set forth in an advertisement, it shall be clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language that implies that the insured may select the benefit level at the time of filing claims is prohibited.
10. Language in an advertisement that implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is prohibited.
11. Advertisements for policies with premiums that are modest because of their limited coverage or limited amount of benefits shall not describe premiums as "low", "low cost", "budget" or use qualifying words of similar import. The use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain are prohibited.
12. Advertisements that state or imply that premiums will not be changed in the future are prohibited unless the advertised policies expressly provide that the premiums will not be changed in the future.
13. An advertisement for a policy that does not require the premium to accompany the application shall not overemphasize that fact and shall clearly indicate under what circumstances coverage will become effective.
14. An advertisement that exaggerates the effects of statutorily mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy is prohibited.

15. An advertisement that implies that a common type of policy or a combination of common benefits is “new”, “unique”, “a bonus”, “a breakthrough”, or is otherwise unusual is prohibited. The addition of a novel method of premium payment to an otherwise common plan of insurance does not render it new.
16. Language in an advertisement that states or implies that each member under a family contract is covered as to the maximum benefits advertised, where that is not the fact, is prohibited.
17. An advertisement that contains statements such as “anyone can apply”, or “anyone can join”, other than with respect to a guaranteed issue policy for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is prohibited.
18. An advertisement that states or implies immediate coverage of a policy is prohibited unless administrative procedures exist so that the policy is issued within fifteen (15) business days after the insurer receives the completed application.
19. An advertisement that contains statements such as “here is all you do to apply”, or “simply” or “merely” to refer to the act of applying for a policy that is not a guaranteed issue policy is prohibited unless it refers to the fact that the application is subject to acceptance or approval by the insurer.
20. An advertisement of accident and sickness insurance sold by direct response shall not state or imply that because no insurance producer will call and no commissions will be paid to producers that it is a low cost plan, or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in the marketing by direct response.
21. Applications, request forms for additional information and similar related materials are prohibited if they resemble paper currency, bonds, stock certificates, etc., or use any name, service mark, slogan, symbol or device in a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services.
22. An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is prohibited.
23. An advertisement that uses words such as “extra”, “special” or “added” to describe a benefit in the policy is prohibited. No advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall use words or phrases such as “tax-free”, “extra cash”, “extra income”, “extra pay”, or substantially similar words or phrases because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.
24. An advertisement of a hospital or other similar facility confinement benefit shall not advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless the statements of the monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. The term “juxtaposition” means side by side or immediately above or below. When the policy contains a limit on the number of days of coverage provided, the limit shall appear in the advertisement.



25. An advertisement of a policy covering only one disease or a list of specified diseases shall not imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.
26. An advertisement that is an invitation to contract for a specified disease policy that provides lesser benefit amounts for a particular subtype of disease, shall clearly disclose the subtype and its benefits. This provision shall not apply to institutional advertisements.
27. An advertisement of a specified disease policy providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount for expenses. Instead, the term "charges" or substantially similar language should be used that does not create the misleading impression that there is full coverage for expenses.
28. An advertisement that describes any benefits that vary by age shall disclose that fact.
29. An advertisement that uses a phrase such as "no age limit," if benefits or premiums vary by age or if age is an underwriting factor, shall disclose that fact.
30. A television, radio, internet, mail or newspaper advertisement or lead-generating device that is designed to produce leads either by use of a coupon, a request to write or e-mail or to call the company or a subsequent advertisement prior to contact shall include information disclosing that a producer may contact the applicant.
31. Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had his or her eligibility for the insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.
32. An advertisement, including invitations to inquire or invitations to contract, shall not employ devices that are designed to create undue fear or anxiety in the minds of those to whom they are directed. Examples of prohibited devices are:
  - a. The use of phrases such as "cancer kills somebody every two minutes" and "total number of accidents" without reference to the total population from which the statistics are drawn;
  - b. The exaggeration of the importance of diseases rarely or seldom found in the class of persons to whom the policy is offered;
  - c. The use of phrases such as "the finest kind of treatment," implying that the treatment would be unavailable without insurance;
  - d. The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures;
  - e. The use of images that unduly emphasize automobile accidents, disabled persons or persons confined in beds who are in obvious distress, persons receiving hospital or medical bills or persons being evicted from their homes due to their medical bills;

- f. The use of phrases such as “financial disaster,” “financial distress,” “financial shock,” or another phrase implying that financial ruin is likely without insurance is only permissible in an advertisement for major medical expense coverage, individual basic medical expense coverage or disability income coverage, and only if the phrase does not dominate the advertisement;
- g. The use of phrases or devices that unduly excite fear of dependence upon relatives or charity; and
- h. The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly.

**B. Exceptions, Reductions and Limitations**

- 1. An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a “benefit builder” or stating “even preexisting conditions are covered after two years”. Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered.
- 2. An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy.
- 3. When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of the preceding paragraph shall prominently disclose the existence of such periods.
- 4. An advertisement shall not use the words “only”, “just”, “merely”, “minimum”, “necessary” or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: “This policy is subject to the following minimum exceptions and reductions.”
- 5. An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any coinsurance factor is prohibited.
- 6. An advertisement for loss-of-time coverage that is an invitation to contract that sets forth a range of amounts of benefit levels is prohibited unless it also states that eligibility for the benefits is based upon condition of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact.
- 7. An advertisement that refers to “hospitalization for injury or sickness” omitting the word “covered” when the policy excludes certain sicknesses or injuries, or that refers to “whenever you are hospitalized”, “when you go to the hospital”, or “while you are confined in the hospital” omitting the phrase “for covered injury or sickness”, if the policy excludes certain injuries or sicknesses, is prohibited. Continued reference to “covered injury or sickness” is not necessary where this fact has been prominently disclosed in the advertisement and where the description of sicknesses or injuries not covered is prominently set forth.

8. An advertisement that fails to disclose that the definition of “hospital” does not include certain facilities that provide institutional care such as a nursing home, convalescent home or extended care facility, when the facilities are excluded under the definition of hospital in the policy, is prohibited.
9. The term “confining sickness” shall be explained in an advertisement containing the term. The explanation might be as follows: “Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors.” Captions such as “Lifetime Sickness Benefits” or “Five-Year Sickness Benefits” are incomplete if the benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as “Lifetime House Confining Sickness Benefits” or “Five-Year House Confining Sickness Benefits” would be permissible.
10. An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited.
11. An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, or other policies providing benefits that are limited in nature, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: “THIS IS A LIMITED POLICY”, “THIS POLICY PROVIDES LIMITED BENEFITS”, or “THIS IS A CANCER ONLY POLICY”.

Some advertisements disclose exceptions, reductions and limitations as required, but the advertisement is so lengthy as to obscure the disclosure. Where the length of an advertisement has this effect, special emphasis must be given by changing the format to show the restrictions in a manner that does not minimize, render obscure or otherwise make them appear unimportant.

**C. Preexisting Conditions.**

1. An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. The use of the term “preexisting condition” without an appropriate definition or description shall not be used.

Negative features must be accurately set forth. Any limitation on benefits including preexisting conditions also must be restated under a caption concerning exclusions or limitations, notwithstanding that the preexisting condition exclusion has been disclosed elsewhere in the advertisement.

2. When an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, an advertisement of the policy shall not state or imply that the applicant’s physical condition or medical history will not affect the issuance of the policy or payment of a claim under the policy. This regulation prohibits the use of the phrase “no medical examination required” and phrases of similar import, but does not prohibit explaining “guaranteed issue.” If an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required.
3. When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant’s signature. For example, the application form shall contain a question or statement substantially as follows:

"Do you understand that this policy will not pay benefits during the first [insert number] [years, months] after the issue date for a disease or physical condition that you now have or have had in the past?

"YES"

Or substantially the following statement:

"I understand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] [years, months] after the issue date on account of disease or physical condition that I now have or have had in the past."

**Section 8      Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination**

- A. An advertisement that is an invitation to contract shall disclose the provisions relating to renewability, cancellability and termination, and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions.
- B. Advertisements of cancellable accident and sickness insurance policies shall state that the company may cancel or renew the contract using language substantially similar to the following: "This policy is renewable at the option of the company," or "The company has the right to refuse renewal of this policy.", or "Renewable at the option of the insurer.", or "This policy can be cancelled by the company at any time."
- C. Advertisements of insurance policies that are guaranteed renewable, cancellable or renewable at the option of the company shall disclose that the insurer has the right to increase premium rates if the policy so provides.
- D. Qualifying conditions that constitute limitations on the permanent nature of the coverage shall be disclosed in advertisements of insurance policies that are guaranteed renewable, cancellable or renewable at the option of the company. Examples of qualifying conditions are (1) age limits; (2) reservation of a right to increase premiums; and (3) the establishment of aggregate limits.
  - 1. Provisions for reduction of benefits at stated ages shall be set forth. For example, a policy may contain a provision that reduces benefits fifty percent (50%) after age sixty (60) although it is renewable to age sixty-five (65). Such a reduction shall be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time shall be set forth.
  - 2. An advertisement for a policy that provides for step-rated premium rates based upon the policy year or the insured's attained age shall disclose the rate increases and the times or ages at which the premiums increase.

**Section 9      Standards for Marketing**

- A. An insurer, directly or through its producers or solicitors, shall:
  - 1. Establish marketing procedures to assure that any comparison of policies by its producers or solicitors will be fair and accurate;
  - 2. Establish marketing procedures assuring excessive insurance is not sold or issued, except this requirement does not apply to group health benefit plans and disability income coverage; and

3. Establish auditable procedures for verifying compliance with this subsection.
- B. The following acts and practices are prohibited:
1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or tending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to take out a policy of insurance with another insurer;
  2. High Pressure Tactics. Employing a method of marketing that has the effect of inducing the purchase of insurance, or tends to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and
  3. Cold Lead Advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.
- C. Summary of Benefits and Coverage (SBC)
1. The SBC Form and Colorado Supplement to the Summary of Benefits and Coverage Form must be in compliance with the requirements of state and federal law, and Colorado Insurance Regulation 4-2-20.
  2. The SBC must contain, in plain language, simple and consistent information about the benefits and coverage of the stated health benefit plan.
  2. If upon review the Division finds that an SBC or the Colorado Supplement to the Summary of Benefits Form is misleading, deceptive, or misrepresentative of the benefits in the stated health benefit plan, the submitting carrier may be found to have violated the marketing standards found at § 10-3-1104, C.R.S.

## **Section 10 Testimonials or Endorsements by Third Parties**

- A. Testimonials and/or endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all of the provisions of this regulation. When a testimonial or endorsement is used more than one (1) year after it was originally given, a confirmation must be obtained.
- B. A person shall be deemed a “spokesperson” if the person making the testimonial or endorsement:
1. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;
  2. Has been formed by the insurer, is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer;
  3. Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or
  4. Is in any way directly or indirectly compensated for making a testimonial or endorsement.

- C. Any person or agency acting as a spokesperson, as defined in the preceding paragraph, who performs any of the following acts in an advertisement shall be considered soliciting an insurance product, and such person or agency shall be a licensed insurance producer or agency pursuant to the Colorado insurance laws:
1. Individual who solicits, negotiates, effects, procures, delivers, renews, continues or binds; or
  2. A corporation, partnership, association, or other legal entity transacting the business of insurance.
- D. The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the fact shall be disclosed in the advertisement by language substantially such as follows: "Paid Endorsement". The requirement of this disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence.
- E. The disclosure requirements of this regulation shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually the scale for TV or radio performances.
- F. An advertisement shall not state or imply that an insurer or an accident and sickness insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed.
- G. When a testimonial refers to benefits received under an accident and sickness insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of four (4) years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

## **Section 11      Use of Statistics**

- A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the current and relevant facts. The advertisement shall not imply that the statistics are derived from the policy advertised unless that is the fact, and when applicable to other policies or plans, shall specifically so state.
1. An advertisement shall specifically identify the accident and sickness insurance policy to which statistics relate and where statistics are given that are applicable to a different policy, it shall be stated clearly that the data does not relate to the policy being advertised.

2. An advertisement using statistics that describe an insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, shall be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for accident and sickness insurance that refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.
- B. An advertisement shall not represent or imply that claim settlements by the insurer are “liberal” or “generous”, or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.
- C. The source of any statistics used in an advertisement shall be identified in the advertisement.

#### **Section 12 Identification of Plan or Number of Policies**

- A. An advertisement that uses the word “plan” without prominently identifying it as an accident and sickness insurance policy is prohibited.
- B. When a choice of the amount of benefits is referred to, an advertisement that is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.
- C. When an advertisement that is an invitation to contract refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that the benefits are provided only through a combination of policies.

#### **Section 13 Disparaging Comparisons and Statements**

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

- A. An advertisement shall not contain statements such as “no red tape” or “here is all you do to receive benefits”.
- B. Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are prohibited unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages.
- C. Advertisements that state or imply that an insurer’s premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are prohibited.

#### **Section 14 Jurisdictional Licensing and Status of Insurer**

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

- B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of the state or the federal government. Terms such as "official" or words of similar import, used to describe any policy or application form are prohibited because of the potential for deceiving or misleading the public.
- C. An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. Approval of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition.
- D. For purposes of Section 14 of this regulation and the multistate plan provisions of the Patient Protection and Affordable Care Act (PPACA), a contract between the Office of Personal Management and a multistate insurer does not constitute approval, endorsement or accreditation by the federal government.

**Section 15 Identity of Insurer**

- A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.
- B. An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.
- C. Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are similar to those used in governmental agencies or by other insurers are not permitted if they may lead the public to believe:
  - 1. That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers;
  - 2. That the advertiser is the same as is connected with or is endorsed by the governmental agencies or the other insurers.
- D. An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description.
- E. An advertisement in the form of envelopes or stationery of any kind may not use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any producer who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.



- F. An advertisement may not incorporate the word “Medicare” in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from Medicare. The advertisement, however, shall not use the phrase “[ ] Medicare Department of the [ ] Insurance Company”, or language of similar import.
- G. An advertisement may not imply that the reader may lose a right or privilege or benefit under federal, state or local law if he or she fails to respond to the advertisement.
- H. The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark.
- I. The use of the name of an agency or “[ ] Underwriters” or “[ ] Plan” in type, size and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer is prohibited.
- J. The use of an address so as to mislead or deceive as to true identity of the insurer, its location or licensing status is prohibited.
- K. An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.
- L. Advertisements used by producers or solicitors of an insurer shall have prior written approval of the insurer before they may be used.
- M. A producer who makes contact with a consumer, as a result of acquiring that consumer’s name from a lead-generating device, shall disclose that fact in the initial contact with the consumer. A producer or insurer may not use names produced from lead-generating devices that do not comply with the requirements of this regulation.

**Section 16      Group or Quasi-Group Implications**

- A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as members, enjoy special rates or underwriting privileges, unless that is the fact.
- B. This regulation prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.
- C. Advertisements that indicate that a particular coverage or policy is exclusively for “preferred risks” or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited.

- D. An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage when that is not the fact.

Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact.

### **Section 17      Introductory, Initial or Special Offers**

- A. An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses the enrollment periods as the usual method of marketing accident and sickness insurance.
1. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than ten (10) days and not more than forty (40) days from the date that the enrollment period is advertised for the first time. This regulation applies to all advertising media, i.e., mail, newspapers, the Internet, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.
  2. This regulation prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact.
  3. The phrase "a particular insurance product" in paragraph 1. of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

- B. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.
- C. Special awards, such as a “safe drivers’ award”, shall not be used in connection with advertisements of accident and sickness insurance.

#### **Section 18      Statements about an Insurer**

An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations.

#### **Section 19      Filing Requirements**

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

#### **Section 20      Enforcement Procedures**

Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in another state, with a notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to regular and periodical inspection by the commissioner. All of these advertisements shall be maintained in a file for a period of either four (4) years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

#### **Section 21      Severability**

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

#### **Section 22      Incorporated Materials**

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

#### **Section 23      Enforcement**

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

## **Section 24      Effective Date**

This regulation is effective April 15, 2014.

## **Section 25      History**

Originally issued as Regulation 75-2, effective December 22, 1975.

Renumbered as Regulation 4-2-3, effective June 1, 1992.

Amended Regulation, effective July 1, 1993.

Repealed and Repromulgated in full, effective February 1, 2001.

Amended Regulation, effective August 1, 2001.

Amended Regulation, effective February 1, 2003.

Amended Regulation, effective May 1, 2010.

Amended Regulation, effective October 1, 2013.

Amended Regulation, effective April 15, 2014.

## **APPENDIX A**

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

- A. Carriers (including health care coverage cooperatives and CO-OPs) offering non-grandfathered individual and small group health and catastrophic health benefit plans, and stand-alone dental plans offering pediatric essential health benefits coverage, for sale inside or outside of the Exchange, must file:
  - 1. The PPACA Marketing Checklist, which must be attached under the Supporting Documentation Tab in SERFF;
  - 2. If a carrier uses a third party to submit a form filing on its behalf, a Letter of Authority, which must be attached under the Supporting Documentation Tab in SERFF.
- B. Carriers (including health care coverage cooperatives and CO-OPs) offering non-grandfathered individual and small group health benefit plans, catastrophic health benefit plans, and/or stand-alone dental plans offering pediatric essential health benefits coverage, for sale inside of the Exchange, additionally must file:
  - 1. A copy of the Carrier Logo, which must be submitted under the Supporting Documentation tab in the Plan Management (Binder) section of SERFF.
  - 2. An SBC form for each cost-sharing variation of each plan, in English and Spanish, which must be submitted under the Supporting Documentation tab in the Plan Management (Binder) section of SERFF. The submitted forms must be in compliance with the requirements of Colorado Insurance Regulation 4-2-20 and federal law.
  - 3. Carriers desiring to have a Marketing Brochure displayed on the Exchange website, which describes the features of all plans within a specific market (i.e. individual or small group), must attach a copy of the brochure under the Associate Schedule Item tab in the Plan Management (Binder) section of SERFF.
    - a. Carriers may submit a copy of the brochure in English and Spanish.

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

**Regulation 4-2-5 HOSPITAL DEFINITION [Repealed eff. 05/01/2010]**

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

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

**Section 1 Authority**

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

**Section 2 Scope and Purpose**

The purpose of this regulation is to standardize the definition of the term "complications of pregnancy" as used in sickness and accident insurance policies covering residents of this state consistent with the commonly perceived connotation of this term by the general public.

**Section 3 Applicability**

This regulation shall apply to all companies and entities marketing or selling sickness and accident policies providing coverage for disability due to sickness issued by an entity subject to the provisions of Part 2 of Article 16 of Title 10, and to those companies and entities marketing or selling individual or group services or indemnity contracts subject to the provisions of Part 3 of Article 16 of Title 10.

**Section 4 Definitions**

For the purposes of this regulation "complications of pregnancy" shall mean:

- A. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy;
- B. Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

**Section 5 Rules**

All companies marketing sickness and accident insurance policies, as defined in this regulation, delivered or issued for delivery in the State of Colorado shall use in each insurance policy or certificate of insurance a definition of the complications of pregnancy no more restrictive than that required by this regulation, and must be in compliance with the requirements found at § 10-16-104(2), C.R.S.

**Section 6 Severability**

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

**Section 7 Enforcement**

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

**Section 8 Effective Date**

This amended regulation shall become effective February 1, 2016.

**Section 9 History**

Originally issued as Regulation 78-16, effective June 30, 1979.

Amended Regulation 78-16, effective October 1, 1983.

Renumbered as Regulation 4-2-6, effective June 1, 1992.

Amended effective November 1, 2000.

Regulation amended, effective March 2, 2010.

Regulation amended effective February 1, 2016.

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

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Requirements for Home Health Services
Section 6	Requirements for Hospice Care
Section 7	Additional Requirements for Home Health Services
Section 8	Severability
Section 9	Enforcement
Section 10	Effective Date
Section 11	History

**Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-16-104(8)(d), C.R.S.

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**Section 2      Scope and Purpose**

The purpose of this regulation is to establish requirements for standard policy provisions, which state clearly and completely the criteria for and extent of coverage for home health services and hospice care and to facilitate prompt and informed decisions regarding patient placement and discharge.

**Section 3      Applicability**

The requirements of this regulation shall apply to:

- A. Insurers subject to the provisions of Part 2 of Article 16 of Title 10, C.R.S. and non-profit hospital, medical surgical, and health service corporations subject to the provisions of Part 3 of Article 16 of Title 10, C.R.S., which provide: hospital, surgical or major medical coverage on an expense incurred basis, except as noted in paragraph B below, issued on or after the effective date hereof and to all such policies renewed after said date, unless the insurer certifies in writing to the Commissioner of Insurance that it no longer issues the type of policy being renewed. "Renewed" or "renewal" means to continue coverage for an additional policy period upon expiration of the current policy period of a policy.
- B. This regulation does not apply to the following:
  - 1. Medicare supplement policies issued under § 10-18-101 et seq., C.R.S.;
  - 2. Credit accident and health policies issued under § 10-10-101 et seq., C.R.S.;
  - 3. This regulation does not apply to health benefit plans as defined at § 10-16-102(32), C.R.S.; and
  - 4. Any insurance policy, contract, or certificate which provides coverage exclusively for:
    - a. Disability loss of income;
    - b. Dental services;
    - c. Optical services;
    - d. Hospital confinement indemnity;
    - e. Accident only; or
    - f. Prescription drug services.

**Section 4      Definitions**

- A. "Benefit period" means, for purposes of this regulation, a hospice care service period of ninety (90) days, during which services are provided on a regular basis.
- B. "Bereavement" means, for purposes of this regulation, that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered during the bereavement period.
- C. "Core services" means, for purposes of this regulation, nursing services, pastoral services, trained volunteers, and psychosocial services routinely provided by hospice staff or volunteers.

- D. "Evaluation" means, for purposes of this regulation, an objective, formal and regular assessment of the functioning of the organization and of the provision of hospice care.
- E. "Home care services" means, for purposes of this regulation, hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.
- F. "Home health agency" means, for purposes of this regulation, an agency which has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act", as amended, for licensed or certified home health agencies and which is engaged in arranging and providing nursing services, home health aide services and other therapeutic and related services.
- G. "Home health services" means, for purposes of this regulation, the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:
1. Skilled nursing services;
  2. Certified and licensed nurse aide services, as defined in § 12-38.1-102(3), C.R.S.;
  3. Physical therapy, occupational therapy, or speech and language pathology services, as such therapy and services are defined in § 12-43.7-101, et seq, C.R.S.;
  4. Social Work Practice services, as defined in § 12-43-403, C.R.S., by a licensed social worker. "Licensed Social Worker" shall have the same meaning as provided in § 12-43-201(5.5), C.R.S.; and
  5. Medical supplies, equipment and appliances suitable for use in the home.
- H. "Home health visit" means, for purposes of this regulation, each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to four (4) hours by a home health aide shall be considered as one visit.
- I. "Homemaker services" means, for purposes of this regulation, services provided to the patient, which include:
1. General household activities including the preparation of meals and routine household care; and
  2. Teaching, demonstrating and providing patient/family with household management techniques that promote self-care, independent living and good nutrition.
- J. "Hospice" means, for purposes of this regulation, a facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychosocial, spiritual, and bereavement care for terminally ill individuals and their families to be available 24 hours, 7 days a week. Hospice services shall be provided in the home, a hospice facility, and/or other licensed health facility. Hospice services include but shall not necessarily be limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services.



- K. "Hospice care" means, for purposes of this regulation, an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care is not limited to medical intervention, but addresses physical, psychosocial, and spiritual needs of the patient. Hospice care is planned, implemented and evaluated by an interdisciplinary team of professionals and volunteers.
- L. Hospice levels of care:
1. "Routine home care" means, for purposes of this regulation, the level of care a patient/family receives according to the interdisciplinary team's plan of care each day the patient is at home and not receiving continuous home care.
  2. "Continuous home care" means, for purposes of this regulation, the level of care received by the patient during a period of medical crisis to achieve palliation and management of acute medical symptoms. The preponderance of care must be nursing care (at least half) and care must be provided for a period of at least eight hours (need not be consecutive) in one calendar day. Home health aide and homemaker services, or both, may be provided to supplement nursing care.
  3. "Inpatient hospice respite care" means, for purposes of this regulation, the level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less.
  4. "General inpatient hospice care" means, for purposes of this regulation, the level of care the patient receives when short-term inpatient care for pain control or acute symptom management cannot be achieved in the home. This level of care must be provided in a licensed facility with the approval of the physician and the hospice.
- M. "Hospice per diem rate" means, for purposes of this regulation, the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.
- N. "Inpatient hospice facility" means, for purposes of this regulation, a facility which shall directly provide inpatient services and may provide any or all of the continuum of hospice services as described in Section 4.E. These services are provided twenty-four (24) hours a day and, to the extent possible, in a homelike setting.
- O. "Inpatient services" means, for purposes of this regulation, hospice services provided to patient/families who require twenty-four (24) hour nursing supervision in a licensed hospice facility or other licensed health facility. In the event that a hospice provides inpatient services in a licensed health facility other than a hospice, such hospice shall maintain administrative control of and responsibility for the provision of all hospice services.
- P. "Interdisciplinary team" means, for purposes of this regulation, a group of qualified individuals, which shall include, but is not limited to, a physician, registered nurse, clergy/counselors, social workers, volunteer director, and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of hospice patient/families.
- Q. "Palliative services" means, for purposes of this regulation, those services and/or interventions which are not curative but which produce the greatest degree of relief from pain and other symptoms of the terminal illness.

- R. "Patient" means, for purposes of this regulation, an individual in the terminal stage of illness who has an anticipated life expectancy of six (6) months or less and who alone or in conjunction with a family member or members, has voluntarily agreed to admission and been accepted into a hospice.
- S. "Patient/family" means, for purposes of this regulation, one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties.
- T. "Personal care" means services provided to a patient in his or her home to meet the patient's physical requirements and/or to accommodate a patient's maintenance or supportive needs.
- U. "Unrelated illness" means, for purposes of this regulation, a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness.

**Section 5 Requirements for Home Health Services**

- A. General Policy Provisions Pertaining to Home Health Care.
  - 1. The policy offering shall provide that home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization. Prior hospitalization shall not be required.
  - 2. The policy offering shall require, as a condition of coverage that home health care services are to be rendered pursuant to a physician's written order, under a plan of care established by the physician in collaboration with a home health care provider.
  - 3. The policy offering may use case management requirements including, but not limited to, authorization of benefits prior to the beginning of services and review of treatment at periodic intervals.
  - 4. The policy may require that all home health services included in the plan of care be coordinated by the home health agency.
- B. Benefits for Home Health Care Services.
  - 1. Benefit levels for home health care services shall not be less than the deductible, coinsurance and stop loss provisions of the overall policy or certificate.
  - 2. The policy or certificate may contain a limitation on the number of home health visits, but no policy offered may provide for fewer than sixty (60) home health visits in any calendar year.
  - 3. The policy offered shall include benefits for the following services:
    - a. Skilled nursing services provided by a Registered or Licensed Nurse;
    - b. Certified nurse aide services;
    - c. Physical therapy;
    - d. Occupational therapy;
    - e. Speech and language pathology;

- f. Respiratory and inhalation therapy;
  - g. Nutrition counseling by a nutritionist or dietitian;
  - h. Social work practice services;
  - i. Medical supplies;
  - j. Prosthesis and orthopedic appliances; and
  - k. Rental or purchase of durable medical equipment.
4. The services identified in subsections B.3.i. through B.3.l. of this section may be included elsewhere in the policy, rather than specifically in the home health benefit provisions.

**C. Limitations and Exclusions.**

- 1. Benefits for home health services may be governed by policy or certificate limitations and exclusions, including but not limited to, exclusion for non-skilled personal care and conditions for surgery excluded in the policy or certificate.
- 2. The following items need not be considered as eligible expenses under home health care benefits:
  - a. Services or supplies for personal comfort or convenience, including homemaker services;
  - b. Services related to well-baby care; and
  - c. Food services or meals other than dietary counseling excluding tube feedings.

**Section 6 Requirements for Hospice Care**

**A. General Provisions Pertaining to Hospice Care.**

- 1. The policy offering shall provide that hospice care services are to be covered when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished.
- 2. The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six (6) months or less, except that benefits may exceed six (6) months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.
- 3. The policy offering shall require a physician's certification of the patient's illness, including a prognosis for life expectancy and the appropriateness for hospice care. The insurer may also require a copy of the patient's plan of care and any changes made to the level of care or to the plan of care.

4. The policy offering may use case management requirements including, but not limited to, authorization of benefits prior to the beginning of services and review of care at periodic intervals.
5. The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

**B. Benefits for Hospice Care Services.**

1. Benefits for hospice care services shall be governed by the deductible, coinsurance and stop-loss provisions of the overall policy or certificate. The details of these provisions will be forwarded and updated to the provider upon authorization of benefits.
2. The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. Any policy offered shall provide a benefit of no less than \$150 per day for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:
  - a. Intermittent and twenty-four (24) hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;
  - b. Intermittent and twenty-four (24) hour on-call social/counseling services; and;
  - c. Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety (90) days.

3. The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:
  - a. Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than \$1400.
  - b. Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in subsection 2 of this section). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;
  - c. Medical supplies;
  - d. Drugs and biologicals;

- e. Prosthesis and orthopedic appliances;
- f. Oxygen and respiratory supplies;
- g. Diagnostic testing;
- h. Rental or purchase of durable equipment;
- i. Transportation;
- j. Physicians services;
- k. Therapies including physical, occupational and speech; and
- l. Nutritional counseling by a nutritionist or dietitian.

**C. Limitations and Exclusions.**

Benefits for hospice care services shall be governed by policy or certificate limitations and exclusions, to the extent that such policy or certificate is not in conflict with the statutory mandate that hospice care be offered with the minimum benefits required by this regulation. The insurer must notify the hospice in writing of any such limitation of benefits, and must do so within two business days of a request to determine if specific services are excluded or authorized under the coverage.

**Section 7 Additional Requirements for Home Health Care Services and Hospice Care**

- A. The offer to a policyholder to purchase home health care and hospice care coverage must be in writing, either by means of a prominent statement or question on the application for the policy or on a separate form.
- B. Nothing in this regulation shall prohibit the insurer from offering a higher level of benefits than required herein.

**Section 8 Severability**

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

**Section 9 Enforcement**

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

**Section 10 Effective Date**

The effective date of this regulation is January 1, 2014.

**Section 11 History**

Originally issued as Colorado Regulation 85-6, effective Oct 1, 1985.  
Amended October 1, 1986.  
Renumbered as Colorado Regulation 4-2-8, July 1, 1992.  
Amended August 1, 1993.

Amended February 1, 1994.  
Amended February 1, 2001.  
Amended regulation, effective March 2, 2011.  
Amended regulation, effective January 1, 2014.

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

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Incorporated Materials
Section 8	Enforcement
Section 9	Effective Date
Section 10	History
Appendix A	FDA Licensed/Approved HIV Tests

**Section 1        Authority**

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

**Section 2        Scope and Purpose**

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

**Section 3        Applicability**

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

**Section 4        Definitions**

- A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- B. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- C. "Insurance coverage" shall mean life insurance policies, annuities, policies of sickness and accident insurance, and other coverage that is not a health benefit plan.
- D. "Person" shall have the same meaning as found at § 10-3-1104.5(2)(f), C.R.S.
- E. "Policy of sickness and accident insurance" shall have the same meaning as found at §10-16-102(50), C.R.S.

**Section 5        Rules**

- A. No person, their agent or employee shall make any inquiry or investigation to determine an insurance applicant's sexual orientation.
- B. Sexual orientation may not be used in the underwriting process or in the determination of insurability.
- C. Insurance support organizations shall be directed by insurers and carriers to not investigate, directly or indirectly, the sexual orientation of an applicant or a beneficiary. All persons shall give written notice to their agents and employees who conduct investigations of applicants for insurance coverage, that they shall not investigate, either directly or indirectly, the sexual orientation of an applicant or beneficiary.
- D. No question shall be used which is designed to establish the sexual orientation of the applicant.
- E. Questions relating to the applicant having or having been diagnosed as having AIDS or HIV infection are permissible if they are designed solely to establish the existence of the condition. For example, straightforward questions on applications are acceptable, such as, "Have you had or been told by a member of the medical profession that you have AIDS or HIV infection?" or "Have you received treatment from a member of the medical profession for AIDS or HIV infection?" are acceptable.
- F. Questions relating to medical and other factual matters intending to reveal the possible existence of a medical condition are permissible if they are not used as a proxy to establish the sexual orientation of the applicant, and the applicant has been given an opportunity to provide an explanation for any affirmative answers given in the application. For example: "Have you had chronic cough, significant weight loss, chronic fatigue, diarrhea, enlarged glands?" These types of questions should be related to a finite period of time preceding completion of the application and should be specific. Such questions should provide the applicant the opportunity to give a detailed explanation.
- G. Persons may not use an applicant's marital status, living arrangements, occupation, gender, medical history, beneficiary designation, or zip code or other territorial classification to establish, or aid in establishing, the applicant's sexual orientation.
- H. For the purpose of rating an applicant for health and life insurance, a person may impose territorial rates only if the rates are based on sound actuarial principles or are related to actual or reasonably anticipated experience.
- I. No adverse underwriting decision shall be made because medical records or any investigation or report indicates that the applicant has demonstrated AIDS or HIV infection related concerns by seeking counseling from health care professionals. Neither shall an adverse underwriting decision be made on the basis of such AIDS or HIV infection related concerns unless a medical test which is a reliable predictor of infection, as defined in subsection J. of this section, has been administered. This subsection does not apply to an applicant seeking treatment and/or diagnosis.
- J. Reliable predictors of infection are delineated in § 10-3-1104.5(3)(d)(I), C.R.S. Pursuant to § 10-3-1104.5(3)(d)(II), C.R.S., the Commissioner designates the following tests, approved by the Colorado Department of Public Health and Environment, as equally reliable predictors of AIDS or HIV infection:
  - 1. A positive HIV-1 p24 antigen test, as defined by the U.S. Department of Public Health and Human Services, Center for Disease Control and Prevention (The Morbidity and Mortality Weekly Report, Volume 95, March 1, 1996).

2. A positive licensed polymerase chain reaction assay for HIV levels in the serum.
3. Two positive or repeatedly reactive commercially licensed serum, oral fluid or urine ELISA or EIA tests and either:
  - a. For serum or oral fluid specimens, a Western Blot test with bands present at any two of p24, gp41 or gp120/gp160;
  - b. for urine specimens, a Western Blot test with bands present at gp160, or
  - c. for serum specimens, a positive HIV 1/2 Multispot test.
- K. To be used for issuing or underwriting a policy, a test described in subsection J. of this section must have been licensed by the U.S. Food and Drug Administration as of the effective date of this regulation. A list of such tests is attached as Appendix A.
- L. If a specific test licensed by the U.S. Food and Drug Administration indicates the presence of the HIV infection or medical condition indicative of the HIV infection, the person shall, before relying on a single test result to deny or limit coverage or to rate the coverage, follow the U.S. Food and Drug Administration confirmation protocols licensed as of the effective date of this regulation and shall use any applicable confirmatory tests or series of tests licensed as of the effective date of this regulation by the U.S. Food and Drug Administration to confirm the indication. The confirmation protocols and applicable follow-up test regimens are attached as Appendix A.
- M. If an applicant is required to take an AIDS or HIV infection test in connection with an application for life or health insurance, the use of such test must be revealed to the applicant and his or her written consent obtained. Test results shall be strictly confidential medical information. However, this regulation is not intended nor should it be interpreted as prohibiting reporting HIV infection to state and local departments of health as provided in § § 25-4-1402 and 25-4-1403, C.R.S.
- N. Persons subject to this regulation may include questions on applications as to whether or not the applicant has tested positive on an AIDS or HIV infection test. However, in the event of an affirmative response, no adverse underwriting decisions shall be made on the basis of such response unless it can be determined that the test protocols in subsections J. and K. of this section above, have been followed.
- O. Insurance coverage which excludes or limits coverages for expenses related to the treatment of AIDS and HIV related illness or complications of AIDS, e.g., opportunistic infection resulting from AIDS, shall not be issued for use in Colorado, except to the extent that such exclusions or limitations are consistent with the exclusions or limitations applicable to other covered illnesses or conditions covered by the policy or certificate.

## **Section 6 Severability**

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



**Section 7      Incorporated Materials**

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

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

**Section 8      Enforcement**

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

**Section 9      Effective Date**

This regulation as amended is effective November 15, 2013.

**Section 10     History**

Originally issued as Regulation 87-2, effective January 1, 1988.  
Renumbered as Regulation 4-2-9, effective June 1, 1992.  
Amended Section IV(J), effective February 1, 1995.  
Amended Regulation, effective March 2, 1999.  
Amended Regulation, effective May 1, 2010.  
Amended Regulation, effective July 1, 2012.  
Amended Regulation effective November 15, 2013.

Appendix A

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

Published as of 7/16/2013

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

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
GS rLAV EIA	HIV-1	EIA	Serum / Plasma	Donor Screen (serum/plasma). Diagnostic (Dried blood spot).	Bio-Rad Laboratories Redmond, WA US License 1109	6/29/1998	BL102866/1031, BL102866/1032
Fluorognost HIV-1 IFA	HIV-1	IFA	Serum / Plasma	Donor Supplemental. Donor Screen (Only in special cases).	Sanochemia Pharmazeutika AG Vienna, Austria US License 1631	2/5/1992	BL103288/0
Cambridge Biotech HIV-1 Western Blot Kit	HIV-1	WB	Serum / Plasma	Donor Supplemental. Diagnostic supplemental.	Maxim Biomedical, Inc. Rockville, MD US License 1741	2/25/1999	BL103843
GS HIV-1 Western Blot	HIV-1	WB	Serum / Plasma	Donor Supplemental	Bio-Rad Laboratories Redmond, WA US License 1109	11/13/1998	BL103655/0
Avioq HIV-1 Microelisa System	HIV-1	EIA	Serum, Plasma, Dried blood spot, Oral Fluid	Diagnostic: For the qualitative detection of antibodies to Human Immunodeficiency Virus Type 1 (HIV-1) in human specimens collected as serum, plasma, dried blood spots, or oral fluid specimens obtained with OraSure®.HIV-1 Oral Specimen Collection Device	Avioq Inc., Rockville, MD	9/21/2009	BP090022/0

HIVAB HIV-1 EIA	HIV-1	EIA	Dried Blood Spot	Diagnostic	Abbott Laboratories Abbott Park, IL US License 0043	4/22/1992	BL103404/0
Maxim Biotech HIV-1 Urine EIA	HIV-1	EIA	Urine	Diagnostic	Maxim Biomedical, Inc. Rockville, MD US License 1741	1/3/1991	BP000009
INSTI™ HIV-1 Antibody Test Kit	HIV-1	Rapid Immunoassay	Plasma / Whole Blood (venipuncture and finger stick)	Diagnostic: For the detection of antibodies to Human Immunodeficiency Virus Type 1 (HIV-1) in human venipuncture whole blood, finger stick blood, or plasma specimens.	bioLytical Laboratories Inc. British Columbia, Canada V6V 2X7	11/29/2010	BP090032/0
Reveal Rapid HIV-1 Antibody Test15	HIV-1	Rapid Immunoassay	Serum / Plasma	Diagnostic	MedMira Laboratories, Inc. Halifax, Nova Scotia Canada B3S 1B3	4/16/2003	BP000023/0
Uni-Gold Recombigen HIV	HIV-1	Rapid Immunoassay	Serum / Plasma / Whole Blood (venipuncture and finger stick)	Diagnostic	Trinity Biotech, plc Bray Co., Wicklow, Ireland	12/23/2003	BP030025/0
GS HIV-1 Western Blot	HIV-1	WB	Dried Blood Spot	Diagnostic Supplemental	Bio-Rad Laboratories Redmond, WA US License 1109	11/13/1998	BL103655/0
Fluorognost HIV-1 IFA	HIV-1	IFA	Dried Blood Spot	Diagnostic Supplemental	Sanochemia Pharmazeutika AG Vienna, Austria US License 1631	5/14/1996	BL103651/0
OraSure HIV-1 Western Blot Kit	HIV-1	WB	Oral Fluid	Diagnostic Supplemental	OraSure Technologies Bethlehem, PA	6/3/1996	BP950004/0
Cambridge Biotech HIV-1 Western Blot Kit	HIV-1	WB	Urine	Diagnostic Supplemental	Maxim Biomedical, Inc. Rockville, MD US License 1741	6/21/2001	BP010009/0

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

	<b>Infectious Agent</b>	<b>Format</b>	<b>Current Sample</b>	<b>Use</b>	<b>Manufacturer</b>	<b>Approval Date</b>	<b>STN</b>
Human Immunodeficiency Virus, Type 1 (HIV-1) Reverse Transcription (RT) Polymerase Chain Reaction (PCR) Assay	HIV-1	PCR	Plasma	Donor Screen: Qualitative detection of HIV-1 ribonucleic acid (RNA) in pools of human Source Plasma comprised of equal aliquots of not more than 512 individual plasma samples.	BioLife Plasma Services, L.P. Deerfield, IL US License 1640	1/31/2007	BL125100/0
UltraQual HIV-1 RT-PCR Assay	HIV-1	PCR	Plasma	Donor Screen: Qualitative detection of HIV-1 ribonucleic acid (RNA) in pools of human Source Plasma comprised of equal aliquots of not more than 512 individual plasma samples.	National Genetics Institute Los Angeles, CA US License 1582	9/18/2001	BL103902/0
COBAS Ampliscreen HIV-1 Test	HIV-1	PCR	Plasma/ Cadaveric serum or plasma	Donor Screen Expanded Indications For Use: Source Plasma donors, other living donors, and organ donors	Roche Molecular Systems, Inc. Pleasanton, CA US License 1636	12/20/2002	BL125059/0
APTIMA HIV-1 RNA Qualitative Assay	HIV-1	HIV-1 Nucleic Acid (TMA)	Plasma/ Serum	Diagnostic: For use as an aid in diagnosis of HIV-1 infection, including acute or primary infection.	Gen-Probe, Inc., San Diego, CA US License 1592	10/4/2006	BL103966/5040

Abbott RealTime HIV-1 Amplification Kit	HIV-1	PCR	Plasma	Patient Monitoring: Quantitation of Human Immunodeficiency Virus type 1 (HIV- 1) on the automated m2000 System. Not intended to be used as a donor screening test or as a diagnostic test to confirm the presence of HIV-1 infection.	ABBOTT Molecular, Inc., Des Plaines, IL	5/11/2007	BP060002/0
Roche Amplicor HIV-1 Monitor Test	HIV-1	PCR	Plasma	Patient Monitoring: Quantitation of Human Immunodeficiency Virus Type 1 (HIV-1) nucleic acid. Not intended as a donor screening test or as a diagnostic test to confirm the presence of HIV-1 infection.	Roche Molecular Systems, Inc. Pleasanton, CA US License 1636	3/2/1999	BP950005/004
COBAS AmpliPrep/COBAS TaqMan HIV-1 Test	HIV-1	PCR	Plasma	Patient Monitoring: Quantitation of Human Immunodeficiency Virus Type 1 (HIV-1) nucleic acid. Not intended to be used as a donor screening test or as a diagnostic test to confirm the presence of HIV-1 infection.	Roche Molecular Systems, Inc. Pleasanton, CA US License 1636	5/11/2007	BP050069/0

Versant HIV-1 RNA 3.0 (bDNA)	HIV-1	Signal amplification on nucleic acid probe	Plasma	Patient Monitoring: Quantitation of Human Immunodeficiency Virus Type 1 (HIV-1) nucleic acid. Not intended to be used as a donor screening test or as a diagnostic test to confirm the presence of HIV-1 infection.	Siemens Healthcare Diagnostics, Inc.	9/11/2002	BP000028/0
ViroSeq HIV-1 Genotyping System with the 3700 Genetic Analyzer	HIV-1	HIV-1 Genotyping	Plasma	Patient Monitoring: For detecting HIV genomic mutations (in the protease and part of the reverse transcriptase regions of HIV) that confer resistance to specific types of antiretroviral drugs, as an aid in monitoring and treating HIV infection.	Celera Diagnostics Alameda, CA	6/11/2003	BK030033/0
Trugene HIV-1 Genotyping Kit and Open Gene DNA Sequencing System	HIV-1	HIV-1 Genotyping	Plasma	Patient Monitoring: For detecting HIV genomic mutations (in the protease and part of the reverse transcriptase regions of HIV) that confer resistance to specific types of antiretroviral drugs, as an aid in monitoring and treating HIV infection.	Siemens Healthcare Diagnostics, Inc.	4/24/2002	BK020005, BK090077, BK080073

**Anti-HIV-1 Testing Service**

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
Home Access HIV-1 Test System	HIV-1	Dried Blood Spot Collection Device	Dried Blood Spot	Diagnostic: Self-use by people who wish to obtain anonymous HIV testing	Home Access Health Corp., Hoffman Estates, IL	7/22/1996	BP950002/0

**Anti-HIV-1 Oral Specimen Collection Device**

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
OraSure HIV-1 Oral Specimen Collection Device	HIV-1	Oral Specimen Collection Device	Oral Fluid	For Use with HIV diagnostic assays that have been approved for use with this device.	OraSure Technologies Bethlehem, PA	12/23/1994	BP910001/0

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

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
GS HIV-2 EIA	HIV-2	EIA	Serum / Plasma	Donor Screen and diagnostic.	Bio-Rad Laboratories Redmond, WA US License 1109	4/25/1990	BL103227/0

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

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
Abbott HIVAB HIV-1/HIV-2 (rDNA) EIA	HIV-1, HIV-2	EIA	Serum / Plasma / Cadaveric Serum	Donor Screen and diagnostic	Abbott Laboratories Abbott Park, IL US License 0043	2/14/1992	BL103385/0

ABBOTT PRISM HIV O Plus assay	HIV- 1, HIV- 2	Chemi- luminescent Immunoassay (ChLIA)	Plasma / Serum / Cadaveric Serum	Donor Screen: Qualitative detection of antibodies to HIV-1 (anti-HIV-1) groups M and O and/or antibodies to HIV-2 (anti-HIV-2) in human serum and plasma specimens. Organ donor screening when specimens are obtained while the donor's heart is still beating, in testing blood specimens to screen cadaveric (non-heart- beating) donors, and as an aid in the diagnosis of HIV- 1 /HIV-2 infection	Abbott Laboratories Abbott Park, IL US License 0043	9/18/2009	BL125318/0
GS HIV- 1/HIV-2 Plus O EIA	HIV- 1, HIV- 2	EIA	Serum / Plasma / Cadaveric Serum	Use with the Ortho Summit™ System (OSS) in the screening of blood donors, also for diagnostics. Diagnostic detection of antibodies to HIV-1 (Groups M and O) and/or HIV-2 in human serum, plasma, and cadaveric serum specimens.	Bio-Rad Laboratories Redmond, WA US License 1109	8/5/2003	BL125030/0, BL125030/10, BL125030/24
ADVIA Centaur HIV 1/O/2 Enhanced ReadyPack Reagents	HIV- 1, HIV- 2	Microparticle Chemi- luminometric Immunoassay	Plasma/ Serum	Diagnostic: For qualitative determination of antibodies to the human immunodeficiency virus type 1, including Group O, and/or type 2 in serum or plasma	Siemens Healthcare Diagnostics, Inc.	5/18/2006	BP050030/0
Ortho VITROS HIV-1/HIV-2	HIV- 1, HIV- 2	EIA	Plasma/ Serum	Diagnostic: For use on the VITROS® 5600 Integrated and VITROS® 3600 Immunodiagnostic Systems	Ortho- Clinical Diagnostics, Inc Raritan, NJ US License 1236	3/27/2008	BP050051/0, BP050051/18



Multispot HIV-1/HIV-2 Rapid Test	HIV-1, HIV-2	Rapid Immunoassay	Plasma / Serum	Diagnostic	Bio-Rad Laboratories Redmond, WA US License 1109	11/12/2004	BP040046/0
SURE CHECK HIV 1/2 ASSAY	HIV-1, HIV-2	Rapid Immunoassay	Finger stick & venous whole blood, serum, plasma	Diagnostic	Chembio Diagnostic Systems, Inc. Medford, NY	5/25/2006	BP050009/0
HIV 1/2 STAT-PAK ASSAY	HIV-1, HIV-2	Rapid Immunoassay	Finger stick & venous whole blood, serum, plasma	Diagnostic	Chembio Diagnostic Systems, Inc. Medford, NY	5/25/2006	BP050010/0
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	HIV-1, HIV-2	Rapid Immunoassay	Whole Blood, Plasma, Oral Fluid	Diagnostic	OraSure Technologies Bethlehem, PA	6/22/2004	BP010047/16
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	HIV-1, HIV-2	Rapid Immunoassay	oral fluid, plasma, venous whole blood	Diagnostic	OraSure Technologies Bethlehem, PA	11/7/2002	BP010047/0

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

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
ARCHITECT HIV Ag/Ab Combo	HIV-1, HIV-2	Chemiluminescent Microparticle Immunoassay (CMIA)	Plasma / Serum	Diagnostic: For detection of antibodies to HIV-1 and HIV-2 and HIV-1 antigen	Abbott Laboratories Abbott Park, IL US License 0043	6/18/2010	BP090080
Bio-Rad GS HIV Ag/Ab Combo EIA	HIV-1, HIV-2	EIA	Plasma / Serum	Diagnostic: For detection of antibodies to HIV-1 and HIV-2 and HIV-1 antigen as an aid in the diagnosis of HIV infection, including in pediatric populations (children as young as two years old).	Bio-Rad Laboratories Redmond, WA US License 1109	7/22/2011	BP100064

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

<b>Trade name(s) (Labeling may be out of date)</b>	<b>Infectious Agent</b>	<b>Format</b>	<b>Current Sample</b>	<b>Use</b>	<b>Manufacturer</b>	<b>Approval Date</b>	<b>STN</b>
Abbott HTLV-I/HTLV-II EIA	HTLV-1, HTLV-2	EIA	Serum / Plasma	Donor Screen	Abbott Laboratories Abbott Park, IL US License 0043	8/15/1997	BL103614/0
ABBOTT PRISM HTLV-I/HTLV-II	HTLV-1, HTLV-2	Chemiluminescent Immunoassay (ChLIA)	Serum / Plasma	Donor Screen: Screening test for individual human donors, including volunteer donors of whole blood and blood components, and other living donors for the presence of anti-HTLV-I/HTLV-II. Also intended for use in testing blood and plasma to screen organ donors when specimens are obtained while the donor's heart is still beating.	Abbott Laboratories Abbott Park, IL US License 0043	1/16/2008	BL103761/0

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

- Section 1      Authority
- Section 2      Scope and Purpose
- Section 3      Applicability
- Section 4      Definitions
- Section 5      Filing Requirements of MEWAs
- Section 6      Authorized Insurance Arrangements
- Section 7      Producer Responsibilities
- Section 8      Continuing Compliance
- Section 9      Severability
- Section 10      Enforcement
- Section 11      Effective Date
- Section 12      History

**Section 1      Authority**

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

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**Section 2      Scope and Purpose**

This regulation is intended to: (1) clarify the information to be filed under the provisions of §10-3-903.5(7)(c), C.R.S. by Multiple Employer Welfare Arrangements (MEWAs) claiming exempt status from formal licensing requirements; and (2) clarify the responsibilities of licensed producers,

**Section 3      Applicability**

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

**Section 4      Definitions**

- A. "Fully insured" means an arrangement where a licensed entity is liable to pay all health care benefits, less any contractual deductibles, coinsurance or copayments to be made by the enrollee. The liability of the licensed entity for payment of the covered services or benefits is directly to the individual employee, member or dependent(s) receiving the health care services or benefits. The contract issuance claims payment and administration and all other insurance related functions remain the ultimate responsibility of the licensed entity.
- B. "Health plan" is an arrangement such as a fund, trust, plan, program or other funding mechanism that provides health care benefits.
- C. "Licensed entity" means a licensed insurance company; health maintenance organization; or nonprofit hospital, medical-surgical, and health service corporation having a certificate of authority to transact business in this state.
- D. "Producer" means a licensed person as defined by Article 2 of Title 10.
- E. "Substantial compliance" means that each benefit provided to an individual covered by a MEWA complies with the essential requirements of each mandated benefit.

**Section 5      Filing Requirements of MEWAs**

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

The following information is required to be filed in order to meet the filing requirements of §10-3-903.5(7)(c), C.R.S. and for the Division of Insurance to make a determination regarding the qualification of a MEWA seeking exemption from licensure requirements.

- A. Evidence that the MEWA has existed continuously since January 1, 1983.
- B. A copy of the sponsor association's organizational documents, membership criteria, ownership and a summary of the activities and benefits, other than health plan coverage, provided to its membership.
- C. A copy of the most recent financial report, which includes at a minimum, a balance sheet, income statement, cash flow report and a detailed listing of assets, as of the MEWA's most recent fiscal year end. The financial report must disclose and support the required five percent (5%) unallocated reserve level.
- D. The method of marketing and enrolling eligible participants.

- E. Actuarial information that must be prepared and signed by a qualified actuary as indicated by §10-7-114(1)(e), C.R.S. This information must include:
  - 1. An opinion that:
    - a. is prepared in a format consistent with that required, and from time to time amended, by the National Association of Insurance Commissioners for commercial health insurers, and
    - b. opines on the adequacy of the health plan reserves and liabilities reflected in the financial report.
  - 2. A copy of the underlying actuarial report supporting such opinion, including all methods and assumptions employed. In addition, the report must evaluate the adequacy of the contribution and funding levels of the health plan for the current and immediately subsequent fiscal year.
- F. A copy of the products offered along with a summary of benefits and a comparison of how each benefit is in substantial compliance with the state's mandated benefit provisions.
- G. Such other relevant information as the Commissioner may request in order to evaluate the financial, actuarial and benefits of the health plan.
- H. A copy of an audited annual financial report within 150 days of the MEWA's fiscal year end.

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

## **Section 6      Authorized Insurance Arrangements**

Qualifying health plans that are not subject to licensure as an insurer under Colorado law are plans that are:

- A. Fully insured;
- B. Established and maintained by a single employer;
- C. Established and subject to a collectively bargained agreement pursuant to §10-3-903.5(7)(b)(II), C.R.S.;
- D. Established by a government entity, pursuant to §10-3-903.5(7)(b)(I), C.R.S.; or
- E. Determined to be in compliance with §10-3-905.3(7)(c), C.R.S. and Section 5 of this regulation.

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

## **Section 7      Producer Responsibilities**

No producer may solicit, advertise, market, accept an application, or place coverage for a person who resides in this state with a MEWA unless the producer first verifies that the MEWA complies with the requirements of this regulation and the provisions of §10-3-903.5, C.R.S. This is accomplished by the producer acquiring a copy of the Division's correspondence determining that the MEWA is in compliance with this regulation and the provisions of §10-3-903.5(7)(c), C.R.S.

Lack of knowledge regarding the compliance of any organization or health plan is not a defense to a violation of this regulation. Any producer involved in the solicitation or sale of health plans through unauthorized insurers or MEWAs which are found not to be in compliance with the provisions of §10-3-903.5, C.R.S. and this regulation are subject to discipline or action including fines, suspension or revocation of their license.

## **Section 8 Continuing Compliance**

In the event that a MEWA ceases to qualify under Section 6 of this regulation, it will be transacting the business of insurance in the State of Colorado without a license and subject to the procedures of Parts 9 and 10 of Article 3 of Title 10, C.R.S. and the provisions of the State Administrative Procedure Act, Part 4 of Title 24, C.R.S. as applicable. Any insurer that may have issued a contract to a health plan is not exempt from the liability under its contract solely due to the unauthorized status of a health plan.

## **Section 9 Severability**

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

## **Section 10 Enforcement**

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

## **Section 11 Effective Date**

This amended regulation shall be effective August 1, 2012.

## **Section 12 History**

Regulation 4-2-10, effective July 1, 1994  
Amended regulation effective October 2, 2006  
Amended regulation effective August 1, 2012

## **Regulation 4-2-11 RATE FILING SUBMISSIONS FOR HEALTH INSURANCE, LIMITED BENEFIT PLANS, EXCESS LOSS INSURANCE, SICKNESS AND ACCIDENT INSURANCE, OTHER THAN HEALTH BENEFIT PLANS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	General Rate Filing Requirements
Section 6	Actuarial Memorandum
Section 7	Additional Rate Filing Requirement by Line of Business
Section 8	Prohibited Rating Practices
Section 9	Severability
Section 10	Enforcement
Section 11	Effective Date
Section 12	History

## **Section 1      Authority**

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

## **Section 2      Scope and Purpose**

The purpose of this regulation is to ensure that health insurance rates on limited benefit plans, excess loss Insurance, sickness, and accident insurance, other than health benefit plans, are not excessive, inadequate or unfairly discriminatory, by establishing the requirements for rate filings.

## **Section 3      Applicability**

This regulation applies to all carriers, as defined in Section 4.D., operating in the State of Colorado. This regulation concerns all health insurance rate filings, including, but not limited to, dental (not covering pediatric dental as an essential health benefit), health coverage plans, limited benefit, long-term care, long-term disability, Medicare supplement, prepaid dental, short-term disability, supplemental health, travel accident/sickness, vision, and excess loss carriers for employers with self-insured health plans, other than health benefit plans. This regulation replaces Emergency Regulation E-13-01 in its entirety.

## **Section 4      Definitions**

- A. "Accident only" means, for the purposes of this regulation, coverage for death, dismemberment, disability, or hospital and medical care caused by or necessitated as the result of accident or specified kinds of accident. "Accident Only" policies cannot include 'sickness' or 'wellness' benefits. If additional benefits are provided they must be fully disclosed and properly labeled.
- B. "Benefits ratio" means, for the purposes of this regulation, the ratio of policy benefits, not including policyholder dividends, to the value of the earned premiums, not reduced by policyholder dividends, over the entire period for which rates are computed to provide coverage. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits ratio calculations must be displayed without the inclusion of active life reserves.
- C. "Carrier" means, for the purposes of this regulation, a carrier as defined in § 10-16-102(8), C.R.S., and includes, but is not limited to, licensed property and casualty insurance companies; licensed life and health insurance companies; non-profit hospital, medical-surgical, and health service corporations; HMOs; prepaid dental companies; and limited service licensed provider networks.
- D. "Covered lives" means, for the purposes of this regulation, the number of members, subscribers and dependents.
- E. "Disability income policy" means, for the purposes of this regulation, a policy that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury. Disability income policies cannot include annual doctor visits or outpatient coverage. If additional benefits are provided, they must be fully disclosed and properly labeled. Group disability income policies must comply with § 10-16-214(3)(c), C.R.S. Additional requirements are also addressed under Section 7 of this regulation.
- F. "Dividends" means, for the purposes of this regulation, both policyholder and stockholder dividends.

- G. "Excessive rates" means, for the purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided or if the rates include a provision for expenses that is unreasonably high in relation to the services rendered. In determining if the rate is excessive, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a rate filing.
- H. "File and use" means, for the purposes of this regulation a filing procedure that requires rates and rating data to be filed with the Division of Insurance (Division) concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates. Under no circumstance shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing. Carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change.
- I. "Filing date" means, for the purposes of this regulation, the date that the rate filing is received at the Division.
- J. "Health benefit plan" shall have the same meaning as defined in § 10-16-102(32), C.R.S.
- K. "Health coverage plan" shall have the same meaning as defined in § 10-16-102(34), C.R.S. and shall mean a contract, certificate or agreement entered into, offered to, or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. For purposes of this regulation, this definition shall not include health benefit plans.
- L. "Health care services" shall have the same meaning as defined in § 10-16-102(33), C.R.S.
- M. "Hospital indemnity" means, for the purposes of this regulation, a policy that provides a stated daily, weekly or monthly payment while the insured is "hospitalized" regardless of expenses incurred and regardless of whether or not other insurance is in force. Hospital Indemnity policies cannot include medical expense, wellness benefits or well-baby care. If additional benefits are provided they must be fully disclosed and properly labeled.
- N. "Implementation date" means, for the purposes of this regulation, the date that the filed or approved rates can be charged to an individual or group.
- O. "Inadequate rates" means, for the purposes of this regulation, rates that are clearly insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a rate filing.
- P. "Lifetime loss ratio", for the purposes of this regulation:
1. "Lifetime loss ratio" is equal to:

- a. The sum of the accumulated value of policy benefits from the inception of the policy form(s) to the end of the experience period and the present value of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage; divided by:
    - b. The sum of the accumulated value of earned premiums from the inception of the policy form(s) to the end of the experience period and the present value of expected earned premium over the entire future period for which the proposed rates are expected to provide coverage.
  2. The lifetime loss ratio should be calculated on an incurred basis as the ratio of accumulated and expected future incurred losses to accumulated and expected future earned premiums. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits or loss ratio calculations must be displayed without the inclusion of active life reserves.
  3. An appropriate rate of interest should be used in calculating the accumulated values and the present values of incurred losses and earned premiums.
  4. Any policy form or forms for which the benefits ratio in any policy duration is expected to differ more than 10% from the lifetime loss ratio shall be assumed to have been priced on a "lifetime loss ratio standard", for purposes of this regulation.
- Q. "Limited benefit health plans" means, for the purposes of this regulation, a policy, contract or certificate issued or offered on a group or individual basis as a supplemental health coverage policy that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles copayments or coinsurance amounts not covered by a health benefit plan. Limited benefit health plans do not include short-term limited duration health benefit policies, contracts or certificates; high deductible plans; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan".
- R. "New policy form or product" means, for the purposes of this regulation, a policy form that has "substantially different new benefits" or unique characteristics associated with risk or cost that are different from existing policy forms. For example: A guaranteed issue policy form is different than an underwritten policy form, a managed care policy form is different than a non-managed care policy form, a direct written policy form is different from a policy sold using producers, etc.
- S. "Non-developed rates" means, for the purposes of this regulation, rates that are established by agreement with a governmental entity through a bidding process or by some other means and include, but are not limited to: rates for Medicare, Title XVIII of the federal "Social Security Act," Medicaid, Title XIX of the federal "Social Security Act," and the State Children's Health Insurance Program (SCHIP), Title XXI of the federal "Social Security Act."
- T. "On-rate-level premium" means, for the purposes of this regulation, the premium that would have been generated if the present rates had been in effect during the entire period under consideration.
- U. "Plan" means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.



- V. "Premium" means, for purposes of this regulation, the amount of money paid by the insured member, subscriber, or policyholder as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier's expectation of the insured's future claim costs and the insured's share of the carrier's claims settlement, operational and administrative expenses, and the carrier's cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.
- W. "Prior approval" means, for the purposes of this regulation, a filing procedure that requires a rate change to be affirmatively approved by the commissioner prior to: distribution, release to agents, collection of premium, advertising, or any other use of the rate. Under no circumstance shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing. The implementation date must be at least sixty (60) days after the date of submission. After the rate filing has been approved by the commissioner, carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change.
- X. "PPACA" or "ACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.
- Y. "Product(s)" means, for the purposes of this regulation, the services covered as a package under a policy form by a carrier, which may have several cost-sharing options and riders as options.
- Z. "Qualified actuary" shall meet the requirements outlined in Colorado Insurance Regulation 1-1-1.
- AA. "Rate" means, for purposes of this regulation, the amount of money a carrier charges as a condition of providing health care coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs, and the insured's share of the carrier's claim settlement, operational and administrative expenses, and the cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the contract. Rates for all health coverages must be filed with the Division.
- AB. "Rate filing" means, for purposes of this regulation, a filing that contains all of the items required in this regulation, and:
1. For individual products, the proposed base rates and all rating factors, the underlying rating assumptions must be submitted. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of trend factors. Support for new product offerings must be provided; and
  2. For group products, proposed base rates, the underlying rating factors and assumptions. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of trend factors. Support for new product offerings must be provided. Groups must meet the definition as "valid groups" as defined by Colorado law in § 10-16-214, C.R.S.
- AC. "Rate increase" shall have the same meaning as defined in § 10-16-102(57), C.R.S., and includes increases in any current rate or any factor, including trend factors, used to calculate premium rates for new or existing policyholders, members or certificate holders. Rate changes applicable to new business only are considered 'rate changes, and must be supported. Rate increases for new business only are subject to prior approval.
- AD. "Rating Period" shall have the same meaning as defined in § 10-16-102(58), C.R.S.

- AE. “Renewed” means, for the purposes of this regulation, a health coverage plan that is deemed renewed upon the occurrence of the earliest of: the annual anniversary date of issue; or the date on which premium rates can be or are changed according to the terms of the plan; or the date on which benefits can be or are changed according to the terms of the plan. If the health care coverage contract specifically allows for a change in premiums or benefits due to changes in state or federal requirements and a change in the health coverage plan premiums or benefits that is solely due to changes in state or federal requirements is not considered a renewal in the health care coverage contract, then such a change will not be considered a renewal for the purposes of this regulation.
- AF. “Retention” means, for the purposes of this regulation, the sum of all non-claim expenses including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses as percentage of total premium (or 100% minus the lifetime loss ratio, for products priced on a lifetime loss ratio standard).
- AG. “Specified disease coverage” means, for the purposes of this regulation, payment of benefits for the diagnosis and treatment of a specifically named disease or diseases. Medical conditions resulting from accidents are not diseases, and cannot be included.
- AH. “Substantially different new benefit” means for the purposes of this regulation, a new benefit that results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product, does not create a new form. Actuarial value is the change in benefit cost as developed when making other benefit relativity adjustments.
- AI. “Trend” or “trending” means, for the purposes of this regulation, any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing. Trend used solely for restating historical experience from the experience period to the rating period, or that is used to project morbidity, is considered a rating assumption.
- AJ. “Trend factors” means, for purposes of this regulation, rates or rating factors which vary over time or due to the duration that the insured has been covered under the policy or certificate, and that reflect any of the components of medical or insurance trend assumptions used in pricing. Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and technology. Insurance trend includes the effect of underwriting wearoff, deductible leveraging, and antiselection resulting from rate increases and discontinuance of new sales. Trend factors include inflation factors, durational factors and the Index Rate for small group business. Rate filings must be submitted on an annual basis to support the continued use of trend factors.
- AK. “Underwriting wearoff” means, for the purposes of this regulation, the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wearoff does not apply to guaranteed issue products.
- AL. “Unfairly discriminatory rates” means, for the purposes of this regulation, charging different rates for the same benefits provided to individuals, or groups, with like expectations of loss; or if after allowing for practical limitations, differences in rates fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

- AM. "Use of the rates" means, for the purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder including advertising, distributing rates or premiums to agents, and disclosing premium quotes. Rates must be filed with the Division and forms must be certified prior to use. It does not include releasing information about the proposed rating change to other government entities or disclosing general information about the rate change to the public.
- AN. "Valid group" shall have the same meaning as defined in § 10-16-214(1), C.R.S. All groups must meet the qualifications as "valid groups". Non-employer groups, including, but not limited to, associations, trusts, unions, and organizations eligible for group life insurance shall be submitted to the Division for approval. Groups formed for the purpose of insurance are prohibited under Colorado law. Multi-state associations must also meet the requirements under § 10-16-214(1), C.R.S. Bona fide associations must meet the requirements under § 10-16-102(6), C.R.S. Trusts must meet the requirements under § 10-7-201, C.R.S., and must be formed by one or more employers or by one or more labor unions, or by one or more employers and one or more labor unions. Union agreements must also be submitted to the Division.
- AO. "Wellness and prevention program" shall have the same meaning as defined in § 10-16-136(7)(b), C.R.S., and apply to individual and small group health coverage plans.

## **Section 5      General Rate Filing Requirements**

All rates associated with health coverage policies, riders, contracts, endorsements, certificates, and other evidence of health coverage, must be filed with the Division prior to issuance or delivery of coverage. All rate filings shall be submitted electronically by licensed entities. Failure to supply the information required in Sections 5, 6 and 7 of this regulation will render the filing incomplete. Incomplete filings are not reviewed for substantive content. All filings that are not returned or disapproved on or before the 30th calendar day after receipt will be considered complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be identified and communicated to the filing carrier on or before the 45th calendar day after receipt. Correction of any deficiency, including deficiencies identified after the 45th calendar day, will be required on a prospective basis, and no penalty will be applied for a non-willful violation identified in this manner. Nothing in this regulation shall render a rate filing subject to prior approval by the commissioner that is not otherwise subject to prior approval as provided by statute.

### **A.      General Requirements**

1.      Prior Approval: Any proposed rate increase for other than dental insurance or a rate increase of 5% or more annually for dental insurance, which is effective on or after January 1, 2009, is subject to prior approval by the commissioner and must be filed with the Division at least sixty (60) calendar days prior to the proposed implementation or use of the rates.
  - a.      If the commissioner approves the rate filing within sixty (60) calendar days after the filing date, the carrier may use the rates immediately upon approval; however, under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing.
  - b.      A carrier who provides insurance coverage under the rates before the proposed implementation date will be considered as using unfiled rates and the Division would take appropriate action as defined by Colorado law.
  - c.      After the rate filing has been approved by the commissioner, carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change.

- d. If the commissioner does not approve or disapprove the rate filing within sixty (60) calendar days after the submission date, the carrier may implement the rates filed.
  - e. Under no circumstances shall the carrier provide insurance coverage under the filed rates until on or after the proposed implementation date specified in the rate filing.
- 2. Existing law also defines a rate increase as any increase in the current rate, including an increase in any base rate, or any rating factor, or continued use of trend factors, used to calculate premium rates, that results in an overall increase in the current rate to any existing policyholder or certificate holder renewing during the proposed rating period of the filing would be considered a prior approval filing. Rate increases as applied to new business only are also subject to prior approval.

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

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

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

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

- a. The benefits provided are not reasonable in relation to the premiums charged;
- b. The rate filing contains rates that are excessive, inadequate, unfairly discriminatory, or otherwise does not comply with the provisions of Sections 5, 6 and 7 of this regulation. In determining if the rate is excessive or inadequate, the commissioner may consider profits, dividends, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice;
- c. The actuarial reasons and data do not justify the requested rate increase;
- d. The rate filing is incomplete; or
- e. The data in the filing failed to adequately support the proposed rates.

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

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

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

4. **New Policy Forms and Products:** Carriers shall not represent an existing product to be a new policy form or product unless it fits the definition set forth in Section 4.S. If a policy form is not a new policy form or product and the rate is increasing, the rate filing will be considered a prior approval filing and the required supporting documentation required by law and regulation will need to be submitted with the filing. If an existing policy form is modified, and it is truly not a new policy form or product, the policy form must be revised to comply with the reasonable modifications provisions of § 10-16-105.1, C.R.S.
5. **Non-Developed Rates:** Non-developed rates are not subject to the filing requirements of Sections 5, 6 and 7 of this regulation.
6. **Required Submissions.**
  - a. Rates on all health insurance policies, riders, contracts, endorsements, certificates, and other evidence of health care coverage, must be filed with the Division prior to issuance or deliverance of coverage.
  - b. All carriers must submit a compliant rate filing whenever the rates charged to new or renewing policyholders or certificate holders differ from the rates on file with the Division. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in the trend or other rating assumptions. Failure to file a rate filing that is compliant with this regulation in these instances will render the carrier as using unfilled rates and the Division will take appropriate action as defined by Colorado law.

- c. All carriers must submit a compliant rate filing on at least an annual basis, at a minimum, to support the continued use of trend factors which change on a predetermined basis. The rate filing must contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate. The rate filing shall contain all of the items required in this regulation. The rate filing must demonstrate that the proposed rate the carrier is proposing to use is not excessive, inadequate or unfairly discriminatory. Note: Trend factors which change on a predetermined basis can be continued for no more than period of twelve (12) months. To continue the use of trend factors that change on a predetermined basis, a filing must be made for that particular form with an implementation date on or before the one-year anniversary of the implementation date of the most recent rate filing.
  - d. All carriers must submit a compliant rate filing when the rates are changed on an existing product even though the rate change pertains to new business only. Colorado experience data for this existing product must be submitted. If Colorado data is partially credible, nationwide data must also be submitted. Detailed support must be provided for the rate change. Support must also be provided to ensure rates are not discriminatory. Assessing different rates for the same product based on issue dates may violate Colorado law.
  - e. All carriers must submit a compliant rate filing within sixty (60) calendar days after commissioner approval of the assumption or acquisition of a block of business. This rate filing should provide detailed support for the rating factors the assuming or acquiring carrier is proposing to use, even if there is no change in the rating factors. The new filing must demonstrate that the rating assumptions are still appropriate.
  - f. Each line of business requires a separate rate filing. Rate filings should not be combined with form filings.
  - g. All carriers are expected to review their experience on a regular basis, no less than annually, and file rate revisions, as appropriate, in a timely manner to ensure that rates are not excessive or inadequate and to avoid filing large rate changes.
  - h. The Form Schedule tab in SERFF must be completed for all rate and form filings. This tab must list policies, riders, endorsements, or certificates referenced in the rate filing. Do not attach actual forms in a rate filing.
7. Withdrawn, Returned, or Disapproved Filings: Filings that have either been withdrawn by the filer, returned by the Division as incomplete or disapproved as unjustified, and are subsequently are resubmitted, will be considered as new filings. If a filing is withdrawn, returned, or disapproved, those rates may not be used or distributed. Nothing in this regulation shall render a rate filing subject to prior approval by the commissioner that is not otherwise subject to prior approval as provided by statute.

8. Submission of Rate Filings: All health, sickness and accident insurance (Title 10, Article 16), health care coverage (Title 10, Article 16), Medicare supplement insurance (Title 10, Article 18), long-term care insurance (Title 10, Article 19), and health excess loss insurance (Title 10, Article 16) rate filings must be filed electronically in a format made available by the Division, unless exempted by rule for an emergency situation as determined by the commissioner. If the carrier fails to comply with these requirements, the carrier will be notified that the filing has been returned as incomplete. Complete electronically submitted rate filings must meet all relevant general requirements, including all necessary rate and policy forms. If a filing is returned as incomplete those rates may not be used or distributed.
9. Carrier Specific: A separate filing must be submitted for each carrier. A single filing, which is made for more than one carrier or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan.
10. Required Inclusions: Rate filings require the submission of an actuarial memorandum in the format as specified under Section 6 of this regulation. A response must be provided for each element under Section 6. The level of detail and the degree of consistency incorporated in the experience records of the carrier are vital factors in the presentation and review of rate filings. Every rate filing shall be accompanied by sufficient information to support the reasonableness of the rate. Valid carrier experience should be used whenever possible. This information may include the carrier's experience and judgment; the experience or data of other carriers or organizations relied upon by the carrier; the interpretation of any statistical data relied upon by the carrier; descriptions of methods used in making the rates; and any other similar information deemed necessary by the carriers. Actual experience must be submitted for changes to existing products. In addition, the commissioner may request additional information used by the carrier to support the rate change request.
11. Confidentiality: All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. The Division does not consider such items as rates, rating factors, rate histories, or side-by-side comparisons of rates or retention components to be confidential. The entire filing, including the actuarial memorandum, cannot be held as confidential. There should be a separate SERFF component for the confidential exhibits, and must be indicated by the icon as confidential in SERFF. Non-confidential information, such as the actuarial memorandum, must be in a separate SERFF component.

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

**B. Actuarial Certification**

Each rate filing shall include a signed and dated statement by a qualified actuary, which attests that, in the actuary's opinion, the rates are not excessive, inadequate or unfairly discriminatory. (The requirements for the actuarial certification for Medicare supplement rate filings can be found in Section 14.H. of Colorado Insurance Regulation 4-3-1. The requirements for the actuarial certification for certain long-term care rate filings can be found in Sections 10.B. and 18.B. of Colorado Insurance Regulation 4-4-1).

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

"This policy DOES NOT include coverage of pediatric dental services as required under The Patient Protection and Affordable Care, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152. Coverage of pediatric dental services is available for purchase in the State of Colorado and can be purchased as a stand-alone plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-certified stand-alone dental plan that includes pediatric dental coverage."

## **Section 6      Actuarial Memorandum**

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

- A. Summary: The memorandum must contain a summary that includes, but is not limited to, the following:
1. Reason(s) for the rate filing: A statement as to whether or not this is a new product offering, a rate revision to an existing product, which includes rates applicable to new business only, or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision should be clearly stated.
  2. Requested rate action: The overall rate increase or decrease amount should be listed.
  3. Marketing method (s): A brief description of the marketing method used for the filed form should be listed. (Agency/Broker, Internet, Direct Response, Other)  
  
If the block is closed, provide the closure date.
  4. Premium classification: This section should state all attributes upon which the premium rates vary.
  5. Product descriptions: This section should describe the benefits provided by the policy, rider or contract.
  6. Policy/Rider or contract: A listing of all policy/rider or contracts impacted by the submission (for standardized Medicare supplement, the plans should be identified).
  7. Age basis: This section must state whether the premiums will be charged on an issue age, attained age, renewal age or other basis and the issue age range of the form should be specified.
  8. Renewability provision: A statement regarding the renewability provision and whether the policy/rider is guaranteed renewable, cancellable, non-cancellable, or optionally renewable.



A. SUMMARY	
1. Reason(s). Detail the reason for the filing: New product offering, a rate revision, change in rating methodology, change in benefits, trend only, etc.	
2. Requested Rate Action (This data should agree with the Rate/Rule tab in SERFF):	Rate Change Without Trend Factor: _____ % Trend Factor applied*: _____ % Rate Change With Trend Factor: _____ % Minimum Change: _____ % Maximum Change: _____ % *Trend 'assumptions' used to project morbidity are NOT considered a rate change.
3. Marketing method(s):  Market Type:	<input type="checkbox"/> Agency / Broker <input type="checkbox"/> Internet <input type="checkbox"/> Direct Response <input type="checkbox"/> Other: <input type="checkbox"/> Closed Block _____ (Date Closed) <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer Only <input type="checkbox"/> Non-Employer: Identify ALL non-employer Groups, and provide the SERFF Tracking Number of Division Approval <input type="checkbox"/> Trust: _____ <input type="checkbox"/> Blanket: _____ <input type="checkbox"/> Union: _____ <input type="checkbox"/> Association: _____ _____ _____
4. Premium Classification(s):	<input type="checkbox"/> Age <input type="checkbox"/> Area Factor <input type="checkbox"/> Gender <input type="checkbox"/> Smoking and/or Tobacco <input type="checkbox"/> Group Size Factor <input type="checkbox"/> Tiers (describe) _____ <input type="checkbox"/> Other _____
5. Product Description(s):	

<b>6. Policy/Rider impacted:</b>	<b>Base Policy #</b> _____ <b>Rider #</b> _____ <b>Rider #</b> _____ <b>Rider #</b> _____ <b>Rider #</b> _____ <b>Rider #</b> _____ <b>Rider #</b> _____
<b>7. Age Basis:</b>	<input type="checkbox"/> <b>Issue Age</b> <input type="checkbox"/> <b>Renewal Age</b> <input type="checkbox"/> <b>Attained Age</b> <input type="checkbox"/> <b>Both Issue &amp; Attained Age</b> <input type="checkbox"/> <b>Other:</b> _____
<b>8. Renewability Provision</b>	<input type="checkbox"/> <b>Guaranteed Renewable</b> <input type="checkbox"/> <b>Cancellable</b> <input type="checkbox"/> <b>Non-cancellable</b> <input type="checkbox"/> <b>Optionally renewable</b> <input type="checkbox"/> <b>Other</b>
<b>Additional Information:</b>	

- B. Assumption, Acquisition or Merger: The memorandum must state whether or not the products included in the rate filing are part of an assumption, acquisition or merger of policies from/with another carrier. If so, then the memorandum must include the full name of the carrier/carriers from which the policies were assumed, acquired or merged, and the closing date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption of the acquisition or assumption rate filing. Commissioner approval of the assumption or acquisition of a block of business is required. See Section 5.A.(6)(e) for acquisition or assumption rate filing requirements.

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

- C. Rating Period: The memorandum must identify the period for which the rates will be effective. At a minimum, the proposed implementation date of the rates must be provided. If the length of the rating period is not clearly identified, it will be assumed to be for twelve months, starting from the proposed implementation date.

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

- D. Underwriting: The memorandum must include a brief description of the extent to which this product will be underwritten, if a new product, or the changes, if any, to the underwriting standards, if an existing product. The memorandum should include the expected impact on the claim costs by duration and in total. The carrier shall state separately the effects of different types of underwriting: medical, financial or other. An example of an acceptable brief description is: "This policy form is subject to limited underwriting with yes/no questions. The expected impact is: duration 1 = .15; duration 2 = .05; duration 3 = .03 decrease in claim costs." Underwriting rate ups are considered rating factors and need to be filed and supported – see paragraph Q., "Other Factors", in this section.
- E. Effect of Law Changes: The memorandum should identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable benefit mandates should be listed, including those with no rating impact. This quantification must include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

<b>E. EFFECT OF LAW CHANGES - Identify and quantify changes resulting from mandated benefits and other law changes.</b>			
<b>Mandated Benefits:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Other Law Changes:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Additional information:</b>			

- F. Rate History: The memorandum must include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) years immediately prior to the filing date, including the implementation date of each rate change.
1. This chart must contain the following information: the filing number (State or SERFF tracking number), the implementation date of each rate change, the average increase or decrease in rate, the minimum and maximum increase and cumulative rate change for the past twelve (12) months.
  2. This chart must contain the cumulative effect of all renewal rates on all rate filings, submitted in the prior year.
  3. The rate history should be provided on both a Colorado basis, as well as an average nationwide basis, if applicable. This information must be provided in the format required by the Division.

F. RATE HISTORY					
Provide the State Tracking Number or SERFF Tracking Number of the Previous Rate Filing _____ and Effective Date: _____ (MM/DD/YYYY) Provide rate changes made in at least the last three (3) years <input type="checkbox"/> N/A (Initial Filing)					
COLORADO					
State Tracking Number or SERFF Tracking Number	Effective Date	% OF CHANGE			
		Minimum	Average	Maximum	Cumulative for past 12 Months
If data is presented in an exhibit, identify the exhibit.					
NATIONWIDE					
Effective Date	Average % of change		Cumulative for past 12 Months		
Additional Information:					

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

G. COORDINATION OF BENEFITS	
Provides actual loss experience net of any savings:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Additional Information:	

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

1. Medicare Supplement and Long-Term Care Policies: See Section 7.E and 7.F of this regulation.
2. Retention Percentage: The actuarial memorandum must list and adequately support each specific component of the retention percentage. The support for a health benefit plan must include a comparison of the most recent levels experienced for each component as shown in the plan's financial statements, with an explanation for any variations between retention loads used and actual experience for each component.
  - a. If the product was not initially priced using a lifetime loss ratio standard, the retention percentage is equal to the sum of all non-claim components of the rate including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses.

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

Each of these specific components must be expressed as a percentage of the earned premium, and should sum to the total carrier retention percentage. Each component should reflect the average assumption used in pricing. Ranges for each assumption and flat dollar amounts are not permitted. The component for profit/contingencies should reflect the target load for profit and contingencies, and not the expected results or operating margin.

The commissioner will evaluate each component for reasonableness and consistency with other similar rate filings. Any change in these components from the previous rate filing must be adequately supported. It should be noted that broad groupings of these components are not permitted.

3. Benefits Ratio Guidelines: The commissioner uses these percentages as guidelines for the acceptability of the carrier's targeted benefits ratio or lifetime loss ratio.
- a. All rate filings justifying the relationship of benefits to premium using one of these guidelines must list the components of the retention percentage, as defined in Subsection H.2 of this section. The commissioner will evaluate these components for reasonableness. Policy forms priced at, or above, these benefits ratios may be unacceptable, if one or more of the retention components is not supported.
- b. The Division recommended benefits ratio guidelines are as listed below. Targeted benefits ratios below these guidelines shall be actuarially justified.

Benefits Ratio Guidelines:

Accident Only	60%
Dental	60%
Hospital Indemnity	60%
Limited Benefit Plans	60%
Long-Term Disability Income	60%
Short-Term Disability Income	60%
Short Term Limited Duration Individual Health Plans	60%
Specified or Dread Disease	60%
Excess Loss	60%
Travel Accident/Sickness	60%
Vision	60%
Long-Term Care	60%
Group Medicare Supplement	75%
Individual Medicare Supplement	65%

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

H. Relation of Benefits to Premium		
Description	Percentage	Support
Commissions		Year 1 _____ % Year 2 _____ % Year 3 _____ % Year 4 _____ % Year 5+ _____ % Other: _____
General expenses		
Premium taxes		
Profit/Contingencies		
Investment Income		
PPACA Fees (if applicable)		
Other Fees (explain)		<input type="checkbox"/> Initial <input type="checkbox"/> Annual
Other (explain)		
Total Retention		

<b>Targeted Loss Ratio:</b> (This number should equal 1 minus the total retention percentage listed above.)	_____ %
<b>Actual Benefit Ratio:</b> (This number should be based on the Experience Period.)	<input type="checkbox"/> Colorado: _____ % <input type="checkbox"/> Nationwide: _____ %

- I. Lifetime Loss Ratio: The memorandum must state whether or not the product was priced initially using a lifetime loss ratio standard. If the product was priced using a lifetime loss ratio standard, then any subsequent rate change request must be based on the same lifetime loss ratio standard unless there has been a material change in assumptions used to price the product including changes in regulations covering the product. Changes to the lifetime loss ratio must be identified and clearly supported. The lifetime loss ratio standard shall consider the effects of investment income.

Any subsequent rate change request shall consider the variance in the expected benefits ratios over the duration of the policy. The rate filing must include the average policy duration in years as of the endpoint of the experience period and the expected benefits ratio, as originally priced, for each year of the experience period.

The rate filing must also include a chart showing actual and expected benefits ratios for both the experience and rating periods. For each year of the experience period the chart must show the actual and expected benefits ratios, and the ratio of these two benefits ratios. For each year of the rating period, the chart must show the projected and expected benefits ratios, and the ratio of these two benefits ratios. It is expected that the carrier is pricing these products to achieve a benefits ratio greater than or equal to the expected benefits ratio for the rating period.

- J. **Provision for Profit and Contingencies:** The memorandum must identify the provision percentage for profit and contingencies, and how this provision is included in the final rate. If material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process. Detailed support must be provided for any proposed load in excess of 7%.

<b>J. PROVISION FOR PROFIT AND CONTINGENCIES</b>	
If material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process.	
<b>1. Provision for Profit and Contingencies:</b>	% Pre-Federal Income Tax ____ After tax ____
<b>2. Proposed load in excess of 7% after tax. Provide detailed support:</b>	
<b>Additional information:</b>	

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

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

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

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

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

2. Provided loss data for an applicable plan that pays on an expense basis must be on an incurred basis with pharmacy data shown separately from medical data, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and incurred but not reported (IBNR) reserves) as of the valuation date. The plan should indicate the number of paid claim months of run out used beyond the end of the incurred claims period.
3. Provided claims experience for an applicable plan that pays on an expense basis should include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims, total medical incurred claims including estimated IBNR claims, actual pharmacy paid on incurred claims, total pharmacy incurred claims including estimated IBNR claims, average covered lives for medical, and average covered lives for pharmacy.
4. Data elements should be aggregated into 12-month annual periods, with yearly "per member, per month" (PMPM) data, and year-over-year PMPM trends listed separately for medical and pharmacy annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends should be identified. The trend assumptions shall be quantified into two categories, medical and insurance, as defined below:
  - a. Medical trend means, for the purposes of this section, the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology.
  - b. Insurance trend means, for the purposes of this section, is the combined effect of underwriting wearoff, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Note: medical trend must be determined or assumed before insurance trend can be determined. Underwriting wearoff means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wearoff does not apply to guaranteed issue products.

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



M. Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three (3) years. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period. Partial credibility must be used if the Colorado data is not fully credible. The formula for determining the amount of partial credibility to assign to the data is the square root (number of life years/full credibility standard) or the square root (number of claims/full credibility standard).

1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and the use of such data must be justified.
2. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is the square root [(# life years or claims)/full credibility standard]. The full credibility standard is defined above, and Colorado data must be provided.
3. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.

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

N. Data Requirements: The memorandum must include, at a minimum, earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least three (3) years.

1. Pharmacy claims data for health benefit plans or an applicable plan that pays on an expense basis should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.
2. National or other relevant data shall be provided in order to support the rates, if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates; rating factors; rating methodology; trend; new benefit options; or new plan designs for an existing product.

3. If the purpose of the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience from the new product is available, experience from a comparable product must be provided, including experience data from other carriers that have been used to support the rates or, the statistical data used in rate development.
4. Support for new policy forms must be provided. If the new policy form is based on an existing policy form, the experience of the existing policy form must be used to support the new policy form, with an explanation as to the benefit differences and the differences in relativity factors between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles or co-payments) does not change the existing form into a “new product”, as defined in this regulation.
5. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used to support the rates must be included in the filing.
  - a. For both renewal filings and new business filings, the experience period must include consecutive data no older than nine months prior to the rate effective implementation date.
  - b. For new business only filings, the experience period must include consecutive data on the existing product no older than nine (9) months prior to the effective implementation date.
6. The loss data must be presented on an incurred basis, including accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information on how the number of claims was calculated.

N. DATA REQUIREMENTS								
Colorado-only basis for at least 3 years. <b>Include</b> national, regional or other appropriate basis, if the Colorado data is not fully credible. The experience period must include consecutive data no older than 9 months prior to the effective implementation date.								
COLORADO DATA								
Year*	Earned Premium	Incurred Claims	Total Estimated Incurred Claims	Estimated IBNR Claims	Loss Ratio	Average Covered Lives	Number of Claims	Colorado On Rate Level Premium
20XX								
20XX								
20XX								
20XX								
20XX								
*This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY								
Above data is for:	<input type="checkbox"/> Existing Product <input type="checkbox"/> Comparable Product <input type="checkbox"/> Other _____ (please specify)							
OTHER DATA								
Year	Earned Premium	Incurred Claims	Total Estimated Incurred Claims	Estimated IBNR Claims	Average Covered Lives	Number of Claims		
20XX								
20XX								
20XX								
20XX								
20XX								
Above data is for:	<input type="checkbox"/> Existing Product <input type="checkbox"/> Comparable Product <input type="checkbox"/> National <input type="checkbox"/> Other (please specify) _____							
Experience Period:	From:		To:					
Detailed description regarding support used for "New Product Offering":								
Additional Information:								

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

<b>O. SIDE-BY-SIDE COMPARISON</b>				<input type="checkbox"/> <b>N/A - New Product only</b>
If the proposed rating factor(s) are new, the memorandum must specifically so state, and provide detailed support for each of the factors.				
<b>Description</b>	<b>Current Rate/ Rating Factor/ Rating Variable</b>	<b>Proposed Rate/ Rating Factor/Rating Variable</b>	<b>Percentage Increase/ Decrease</b>	<b>Detailed Support for Rating Factor Change</b>
If the above table is not used, please identify the location of the Side-by-Side Comparison in the rate filing:				
Description and detailed support for new rating factor(s):				
Additional Information:				

- P. Benefits Ratio Projections: The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. The comparison should be shown in chart form; listing projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should be included. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.

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

- Q. Other Factors: The memorandum must clearly display or clearly reference all other rating factors and definitions used, including the area factors, age factors, gender factors, etc., and provide support for the use of each of these factors in the new rate filing. The same level of support for changes to any of these factors must be included in all renewal rate filings. In addition, the commissioner expects each carrier to review each of these rating factors every five (5) years, at a minimum, and provide detailed support for the continued use of each of these factors in a rate filing. Gender factors shall not vary for individual health care coverage effective on or after January 1, 2011. See Section 8.C. of this regulation. Note: this requirement does not apply to Medicare supplement coverage.

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

- R. Rating manuals and underwriting guidelines: A rating manual and the underwriting guidelines that affect the calculation of the rates must be submitted to the Division for each new product.

All changes to the rating manual and/or underwriting guidelines must be filed with the Division in an appropriate rate filing. Rating manuals and underwriting guidelines based on an accept/reject basis are not required to be filed. Rate pages and rate manuals must be attached to the Rate/Rule Schedule tab in SERFF. All other documents must be attached to the Supporting Documents tab in SERFF.

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

## **Section 7 Additional Rate Filing Requirement by Line of Business**

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

- A. Individual: Renewal rates for individual health coverage plans shall not be affected by the health status or claims experience of the individual insured. A "claims experience factor", or any other part of the renewal rate calculation, which is based in whole or in part upon the health status or claims experience of the individual insured is prohibited.
- B. Wellness and Prevention Programs: A carrier offering an individual health coverage plan or a small group plan in this state may offer incentives or rewards to encourage the individual or small group and other covered persons under the plan to participate in wellness and prevention programs, pursuant to § 10-16-136, C.R.S., and shall be subject to the following:
1. The incentives or rewards shall be made to all participants in the program and may include, but are not limited to: premium discounts or rebates; modifications to copayment, deductible, or coinsurance amounts; the absence of a surcharge; the value of a benefit that would otherwise not be provided; or a combination of these incentives or rewards.
  2. Incentives or rewards provided under the program shall not be based upon the size or composition of the small group.
  3. The program shall be voluntary and a penalty shall not be imposed on a covered person or small group for not participating.

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4. The carrier shall not use the wellness and prevention programs, or incentives or rewards under such programs, to increase rates or premiums for any individuals or small groups covered by the carrier's plans.
  5. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:
    - a. Does not shift costs to individuals or small groups that decline to participate in the program; and
    - b. Is reasonably related to the program.
  6. For wellness and prevention programs providing incentives or rewards which are based upon satisfaction of a standard related to a health risk factor:
    - a. The carrier shall provide in each filing proof that the wellness program has been accredited by a nationally recognized nonprofit entity that accredits wellness programs pursuant to § 10-16-136(3.7), C.R.S.;
    - b. The carrier shall document that the wellness program is scientifically proven to improve health and that the incentives are not provided based on an individual's actual health status; and
    - c. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:
      - (1) Does not exceed 20% of the premium; and
      - (2) Is not a subterfuge for discriminating based upon a health status-related factor.
    - d. For purposes of small group plans, the incentives or rewards attributable to the individual (and all similarly situated individuals) shall be applied to that individual (and all similarly situated individuals), and shall not be distributed to the entire group.
  7. The carrier shall include any information as required by the commissioner to ensure that the filed rates, in conjunction with the incentives and rewards available under the wellness program, are not excessive, inadequate, or unfairly discriminatory.
- C. Large Group Health Coverage Plans: Large group health coverage plan contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing must contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing should also contain an example of how the large group health rates are calculated. While the final rate charged to the large group may differ from the initial quote, all rating variables must be on file with the Division.

Although it is not necessary to submit a separate rate filing for each large group policy issued, each carrier must retain detailed records for each large group policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each group insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate should be identified in the detail material and lie within the range identified in the rate filing on file with the Division. The carrier shall make all such information available for review by the commissioner upon request. All such requests must be made at least three (3) business days prior to the date of review.

The rates for subgroups must be determined in an actuarially sound manner using credible data. The methodology for determining these rates must be on file with the Division and any changes in the methodology must be filed with the Division.

Groups must meet the requirements as 'valid groups' under § 10-16-214(1)(a), C.R.S. All 'non-employer' groups must be approved by the Division. Detailed support must be provided explaining how each non-employer group meets the requirements of a valid group. Groups formed for the sole purpose of insurance are prohibited.

- D. Valid Multi-State Association Groups: To be considered a valid multi-state group, a group shall meet the requirements of § 10-16-214(1)(b) and (2), C.R.S. All associations must be identified and the by-laws and articles of association for each association must be submitted to the Division for approval. Once the association has been approved by the Division, the filing must provide the SERFF Tracking Number of the approval filing when submitting all rate filings for the association, and include confirmation that the coverage requirements of the association are still being met.
- E. Medicare Supplement: A Medicare supplement policy is defined in § 10-18-101(4), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4-3-1 and § § 10-18-101 to 109, C.R.S. If the requirements of both Colorado Insurance Regulation 4-3-1 and this regulation are not met, the filing will be considered incomplete and returned to the carrier. Medicare supplement filings require prior approval. (The requirements for the actuarial certification for Medicare supplement rate filings can be found in Section 14.H of Colorado Insurance Regulation 4-3-1. Additional rating requirements can be found in Sections 10.E, 13 and 14.F – J of that same regulation). Although the Modernized plans must be filed separately from the closed OBRA '90 Standardized plans, the experience for the Modernized plans and the OBRA '90 Standardized plans must be included in each filing type. The experience must be reported separately by plan for each type, as well as combined by plan for Modernized and Standardized, and totaled as all plans. This must be done for all Colorado plans. Nationwide data must be provided if Colorado data is not fully credible.
- F. Long-Term Care: Long-term care insurance is defined in § 10-19-103(5), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4-4-1 and § § 10-19-101 to 115, C.R.S. If the requirements of both Colorado Insurance Regulation 4-4-1 and this regulation are not met, the filing will be considered incomplete and returned to the carrier. The filing must also:
  - 1. Demonstrate that investment income has been considered in the development of the rate;
  - 2. Provide the expected benefits ratios for both the experience period and the projection period on an annual basis;
  - 3. Provide the ratio of the actual benefits ratio to the expected benefits ratio for each year of the life of the policy on both a durational and calendar year basis; and

4. Provide a discussion as to how the original pricing assumptions have changed historically, and how the assumptions for the future period compare to the original pricing assumptions and the current rating assumptions.
- G. Disability Income: The filing must demonstrate that investment income has been considered in the development of the rate. Each must be supported separately. Group disability income plans must also meet the requirements under § 10-16-214(3)(c), C.R.S.
- H. Limited Service Licensed Provider Network (LSLPN): Rates and premiums for products issued by an LSLPN are to be determined on a fixed prepayment basis. Therefore, no LSLPN product may be issued on a cost-plus or retrospective rating basis.

## **Section 8 Prohibited Rating Practices**

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

- A. Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating;
- B. The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income;
- C. For individual health coverage plans other than Medicare supplement, rates shall not vary due to the gender of the individual policyholder, enrollee, subscriber, or member for rates effective on or after January 1, 2011, pursuant to § 10-16-107(1.5)(b), C.R.S; and
- D. For individual health insurance plans, other than Medicare supplement, the use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss. It is the expectation of the commissioner that areas of the state with like expectations of loss must be treated in a similar manner. Also, policyholders utilizing the same provider groups should be rated in a like manner. The use of zip codes in determining rating factors can result in inequities. Unless different rating factors can be justified based upon different provider groups or other actuarially sound reasons, the following guidelines shall be followed whenever zip codes are used in determining a carrier's rating factors:
  1. All zip codes in the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor, with the following possible exceptions:
    - a. The following zip codes in Elbert County: 80101, 80106, 80107, 80117;
    - b. The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136;
    - c. The following zip codes in El Paso County: 80132, 80133; and
    - d. The following zip codes in Boulder County: 80025, 80026, 80027, 80028.



2. In addition, the following zip codes outside the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor as the 800-802 three-digit zip code groups:
  - a. The following zip codes in Jefferson County: 80401-80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465.
  - b. The following zip codes in Adams County: 80614, 80640.
3. All zip codes in the 809 three-digit zip code group are considered part of the Colorado Springs metropolitan area and shall receive the same rating factor. In addition, the following zip codes in El Paso County, which lie outside the 809 three-digit zip code group shall be considered part of the Colorado Springs metropolitan area and shall receive the same rating factor as the 809 three-digit zip code group: 80809, 80817, 80819, 80829, 80831, 80840, 80841.

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

#### **Section 9      Severability**

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

#### **Section 10     Enforcement**

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

#### **Section 11     Effective date**

This regulation is amended effective October 1, 2013.

#### **Section 12     History**

Regulation 4-2-11, effective November 1, 1992.  
Regulation Repealed and Re-promulgated, effective February 1, 1999.  
Regulation amended effective January 1, 2001.  
Regulation amended effective December 1, 2005.  
Regulation amended effective December 1, 2007.  
Emergency Regulation 08-E-4 was effective July 1, 2008.  
Regulation amended effective October 1, 2008.  
Regulation amended effective February 1, 2009.  
Regulation amended effective July 1, 2009.  
Regulation amended effective January 1, 2010.  
Regulation 4-2-11 amended, effective May 1, 2010.  
Regulation 4-2-11 amended, effective January 1, 2011.  
Regulation 4-2-11 amended, effective January 1, 2012.  
Regulation 4-2-11 amended, effective February 1, 2013.

Regulation 4-2-11 amended, effective October 1, 2013.

**Regulation 4-2-13      Repealed in Full [eff. 01/01/2010]**

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

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

**Section 1      Authority**

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

**Section 2      Scope and Purpose**

The purpose of this regulation is to describe the entities subject to the provisions of § § 10-16-121, and 10-16-705, C.R.S., which concern the required provisions in insurance carrier's contracts with health care providers and intermediaries, and to establish how those entities shall meet the requirements of the above sections.

**Section 3      Applicability**

The provisions of this regulation shall apply to all contracts that concern the delivery, provision, payment or offering of care or services covered by a managed care plan that are entered into between a carrier and a provider or its representative, or between a carrier and an intermediary.

**Section 4      Definitions**

As used in this regulation, and unless the context requires otherwise:

- A. "Carrier" is defined in § 10-16-102(8), C.R.S.
- B. "Intermediary" is defined in § 10-16-102(40), C.R.S.
- C. "Managed care plan" is defined in §10-16-102(43), C.R.S.
- D. "Utilization management" is defined in § 10-16-1002(10), C.R.S.
- E. "Utilization review" is defined in § 10-16-112(1)(b), C.R.S.

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**Section 5        Rules**

- A.        Every contract between a carrier that has covered lives in Colorado and a provider or its representative that concerns the delivery, provision, payment or offering of care or services covered by a managed care plan that is issued, renewed, amended or extended shall contain provisions substantially similar to the following:
1.        “No individual or group of providers covered by this contract shall be prohibited from protesting or expressing disagreement with a medical decision, medical practice of [name of carrier] or an entity representing or working for the carrier (e.g., a utilization review company).”
  2.        “[Name of carrier] or an entity representing or working for the carrier shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of an individual or group of providers covered by this contract.”
  3.        “[Name of carrier] shall not terminate this contract because a provider covered by this contract expresses disagreement with a decision by [name of carrier] or an entity representing or working for such carrier to deny or limit benefits to a covered person or because the provider discusses with a current, former or prospective patient any aspect of the patient’s medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions or a plan, or a provider’s personal recommendation regarding selection of a health plan based upon the provider’s personal knowledge of the health needs of such patients.”
- B.        Every contract between a carrier and an intermediary that concerns the delivery, provision, payment or offering of care or services covered by a managed care plan that is issued, renewed, amended or extended shall contain a provision requiring that the underlying contract authorizing the intermediary to negotiate and execute contracts with carriers, on behalf of providers, contain provisions substantially similar to the following:
1.        “No individual or group of providers covered by any contract executed by [name of intermediary] shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of the carrier or an entity representing or working for such carrier (e.g. a utilization review company);”
  2.        “The carrier or an entity representing or working for such carrier shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of an individual or group of providers covered by any contract executed by [name of intermediary];”
  3.        “The carrier shall not terminate any contract executed by [name of intermediary] because any individual or group of providers covered by the contract:
    - a.        Expresses disagreement with a decision by the carrier or an entity representing or working for such carrier to deny or limit benefits to a covered person,
    - b.        Assists the covered person to seek reconsideration for the carrier’s decision, or
    - c.        Discusses with a current, former or prospective patient any aspect of the patient’s medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider’s personal recommendation regarding selection of a health plan based on the provider’s personal knowledge of the needs of such patients.”

- C. Any contract entered into by a carrier with one or more intermediaries to conduct utilization management, utilization reviews, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, or disease management programs, when issued, renewed, amended or extended shall contain provisions requiring the intermediary to:
1. Comply with the same standards, guidelines, medical policies, and benefit terms of the carrier; and
  2. Indicate the name of the intermediary and the name of the carrier for which it is conducting the work when making any payment to a health care provider on behalf of the carrier.

## **Section 6 Severability**

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

## **Section 7 Enforcement**

Noncompliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process. Among others, the penalties provided for in §10-3-1108, C.R.S. may be applied.

## **Section 8 Effective Date**

This regulation shall become effective on January 15, 2014.

## **Section 9 History**

New regulation effective October 30, 1996.  
Amended regulation effective December 1, 2009.  
Amended regulation effective January 15, 2014.

## **Regulation 4-2-16 WOMEN'S ACCESS TO OBSTETRICIANS, GYNECOLOGISTS AND CERTIFIED NURSE MIDWIVES UNDER MANAGED CARE PLANS [Repealed eff. 01/01/2014]**

## **Regulation 4-2-17 PROMPT INVESTIGATION OF HEALTH CLAIMS INVOLVING UTILIZATION REVIEW AND DENIAL OF BENEFITS AND RULES RELATED TO INTERNAL CLAIMS AND APPEALS PROCESSES**

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|------------|---|
| Section 1  | Authority   |
| Section 2  | Scope and Purpose   |
| Section 3  | Applicability   |
| Section 4  | Definitions   |
| Section 5  | Compliance Requirements   |
| Section 6  | Standard Utilization Review   |
| Section 7  | Expedited Utilization Review  |
| Section 8  | Emergency Services  |
| Section 9  | Peer-to-Peer Conversation   |
| Section 10 | First Level Review  |
| Section 11 | General Requirements for First Level Review Meetings and Voluntary Second Level Review Meetings |

Section 12	Expedited Review of an Adverse Determination
Section 13	Rescission
Section 14	Severability
Section 15	Enforcement
Section 16	Effective Date
Section 17	History

## **Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-3-1110, 10-16-109, and 10-16-113(2) and (10), C.R.S.

## **Section 2      Scope and Purpose**

The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of § § 10-3-1104(1)(h), 10-16-409(1)(a), and 10-16-113, C.R.S., in situations involving utilization review and certain denials of benefits for treatment, as well as rescission, cancellation, or denial of coverage based on an eligibility determination, as described herein. Among other things, § 10-3-1104(1)(h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from health coverage plans; promptly provide a reasonable explanation of the basis in the health coverage plan in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and refrain from denying a claim without conducting a reasonable investigation based upon all available information.

This regulation is designed to provide minimum standards for handling appeals and grievances involving utilization review determinations, certain denials of benefits for treatments excluded by health coverage plans, and as otherwise required by § 10-16-113, C.R.S.

## **Section 3      Applicability**

The provisions of this regulation shall apply to all health coverage plans, but shall not apply to automobile medical payment policies, worker's compensation policies or property and casualty insurance. Where a decision concerning a claim is not based on utilization review, a carrier is not required to use the specific procedures outlined in this regulation. However, this regulation shall apply to a carrier's denial of a benefit because the treatment is excluded by the health coverage plan if the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply. Nothing in this regulation shall be construed to supplant any appeal or due process rights that a person may have under federal or state law.

## **Section 4      Definitions**

- A. "Adverse determination" means, for purposes of this regulation, a determination by a carrier or its designee that a request for a pre-service or post-service benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirement for medical necessity, or that the benefit is not appropriate, effective, efficient, is not provided in or at the appropriate health care setting or level of care, or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated. An adverse determination also includes a denial for a benefit excluded by a health coverage plan for which the claimant is able to present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit. An adverse determination also includes a rescission or cancellation of coverage not attributed to a failure to pay premiums that is applied retroactively, as well as a denial of coverage to an individual based on an initial eligibility determination, however, a physician is not required to evaluate an appeal of these types of adverse determinations.

- B. "Ambulatory review" means, for purposes of this regulation, a utilization review of health care services performed or provided in an outpatient setting.
- C. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- D. "Case management" means, for purposes of this regulation, a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.
- E. "Clinical peer" means, for purposes of this regulation, a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.
- F. "Complaint" means, for purposes of this regulation, a written communication primarily expressing a grievance.
- G. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.
- H. "Date of receipt of a notice" means, for purposes of this regulation, the date that shall be calculated to be no less than three (3) calendar days after the date the notice is postmarked by the carrier.
- I. "Designated representative" means, for purposes of this regulation:
  - 1. A person, including the treating health care professional or a person authorized by paragraph 2. of this subsection I., to whom a covered person has given express written consent to represent the covered person; or
  - 2. A person authorized by law to provide substituted consent for a covered person, including but not limited to a guardian, agent under a power of attorney, a proxy, or a designee of the Colorado Department of Health Care Policy and Financing; or
  - 3. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.
- J. "Discharge planning" means, for purposes of this regulation, the formal process for determining, prior to discharge from a facility or service, the coordination and management of the care that a patient receives following discharge from a facility or service.
- K. "Emergency medical condition" means, for purposes of this regulation, the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.
- L. "Grievance" means, for purposes of this regulation, a circumstance regarded as a cause for protest, including the protest of an adverse determination.
- M. "Health care professional" means, for purposes of this regulation, a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.
- N. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.

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- O. "Life or limb threatening emergency" means, for purposes of this regulation, any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.
- P. "Medical professional" means, for purposes of this regulation, an individual licensed pursuant to the "Colorado Medical Practice Act", article 36 of title 12, C.R.S., or, for dental plans only, a dentist licensed pursuant to the "Dental Practice Law of Colorado", article 35 of title 12, C.R.S., acting within his or her scope of practice.
- Q. "Prospective review" means, for purposes of this regulation, a utilization review conducted prior to an admission or course of treatment, also known as a "pre-service review".
- R. "Provider" shall have the same meaning as found at §10-16-102(56), C.R.S.
- S. "Rescission" means, for the purposes of this regulation, the cancellation or discontinuance of coverage that has a retroactive effect. This includes a cancellation that treats a policy as void from the time of enrollment, and a cancellation that voids benefits paid up to a year before the cancellation takes place. A rescission of coverage shall be treated as an adverse determination. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance is exclusively prospective, or the cancellation or discontinuance is retroactive only to the extent attributable to a failure to pay premiums or contributions toward the cost of coverage in a timely manner.
- T. "Retrospective review" means, for purposes of this regulation, utilization review conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment, also known as a "post-service review".
- U. "Second opinion" means, for purposes of this regulation, an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the necessity and appropriateness of the initial proposed health service.
- V. "Voluntary second level review" means, for the purposes of this regulation, a request for a review of an adverse determination from a first-level appeal which is available to persons covered under a group health coverage plan.
- W. "Stabilized" means, for purposes of this regulation, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred.
- X. "Urgent care request" means, for purposes of this regulation:
1. A request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination that:
    - a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently; or
    - b. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

2. Except as provided in paragraph 3. of this subsection W., in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
  3. Any request that a physician with knowledge of the covered person's medical condition determines and states is an urgent care request within the meaning of paragraph 1. shall be treated as an urgent care request.
- Y. "Utilization review" means, for purposes of this regulation, a set of formal techniques designed to monitor the use of, or evaluate the necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

## **Section 5 Compliance Requirements**

- A. A carrier that does not use a procedure for investigating claims involving utilization review that is consistent with this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information. (§ 10-3-1104(1)(h)(IV), C.R.S.)
- B. A carrier that uses standards in the review of claims involving utilization review that are not in compliance with the rules contained in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier use reasonable standards for the prompt investigation of claims. (§ 10-3-1104(1)(h)(III), C.R.S.)
- C. A carrier that does not investigate claims involving utilization review within the time frames set out in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly investigate claims. (§ 10-3-1104(1)(h)(II), C.R.S.)
- D. A carrier that does not follow the procedures for explaining the basis of a utilization review decision set forth in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim. (§ 10-3-1104(1)(h)(XIV), C.R.S.)
- E. A carrier that does not allow an appeal, consistent with the procedures set forth in this regulation, of a benefit denial for a treatment excluded by the health coverage plan when the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information. (§ 10-3-1104(1)(h)(IV), C.R.S.)



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**Section 6      Standard Utilization Review**

- A. A carrier shall maintain written procedures pursuant to this section for making utilization review decisions and for notifying covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.
- B. Prospective review determinations.
  - 1. Time period for determination and notification.
    - a. Subject to subparagraph b. of paragraph 1., a carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) calendar days after the date the carrier receives the request. Whenever the determination is an adverse determination, the carrier shall make the notification of the adverse determination in accordance with subsection E.
    - b. The time period for making a determination and notifying the covered person of the determination pursuant to subparagraph a. of paragraph 1. may be extended one (1) time by the carrier for up to fifteen (15) calendar days, provided the carrier:
      - (1) Determines that an extension is necessary due to matters beyond the carrier's control; and
      - (2) Notifies the covered person prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the carrier expects to make a determination.
    - c. If the extension under subparagraph b. of paragraph 1. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:
      - (1) Specifically describe the required information necessary to complete the request; and
      - (2) Give the covered person at least forty-five (45) calendar days from the date of receipt of a notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline shall be extended to the next business day.
  - 2. Failure to meet the carrier's filing procedures.
    - a. Whenever the carrier receives a prospective review request from a covered person that fails to meet the carrier's filing procedures, the carrier shall notify the covered person of this failure and provide in the notice information on the proper procedures to be followed for filing a request.
    - b. Required notice.
      - (1) The notice required under subparagraph a. of paragraph 2. shall be provided, as soon as possible, but in no event later than five (5) calendar days following the date of the failure.

- (2) The carrier shall provide the notice in writing.
  - c. The provisions of paragraph 2. shall apply only in the case of a failure that:
    - (1) Is a communication by a covered person that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
    - (2) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.
  - 3. For an adverse determination regarding a prospective review decision that occurs during a covered person's hospital stay or course of treatment, the health care service or treatment that is the subject of an adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the carrier.
  - 4. The requirements of subsection B. apply to all written requests involving utilization review received by the carrier which are submitted by a covered person, the covered person's designated representative, or provider requesting a determination of coverage for a specific health care service or treatment for a specific member.
- C. Retrospective review determinations.
  - 1. For retrospective review determinations, a carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, but in no event later than thirty (30) calendar days after the date of receiving the benefit request. If the determination is an adverse determination, the carrier shall provide notice of the adverse determination to the covered person in accordance with subsection E.
  - 2. Time period for determination and notification.
    - a. The time period for making a determination and notifying the covered person of the determination pursuant to paragraph 1. may be extended one (1) time by the carrier for up to fifteen (15) calendar days, provided the carrier:
      - (1) Determines that an extension is necessary due to matters beyond the carrier's control; and
      - (2) Notifies the covered person prior to the expiration of the initial thirty-day time period, of the circumstances requiring the extension of time and the date by which the carrier expects to make a determination.
    - b. If the extension under subparagraph a. of paragraph 2. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:
      - (1) Specifically describe the required information necessary to complete the request; and

- (2) Give the covered person at least thirty (30) calendar days from the date of receipt of a notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline shall be extended to the next business day.

**D. Calculation of time periods.**

1. For purposes of calculating the time periods within which a determination is required to be made under subsections B. and C., the time period within which the determination is required to be made shall begin on the date the request is received by the carrier in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.
2. Extensions.
  - a. If the time period for making the determination under subsection B. or C. is extended due to the covered person's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the carrier sends the notification of the extension to the covered person until the earlier of:
    - (1) The date on which the covered person responds to the request for additional information; or
    - (2) The date on which the specified information was to have been submitted.
  - b. If the covered person fails to submit the information before the end of the period of the extension, as specified in subsection B. or C., the carrier may deny the authorization of the requested benefit.

**E. Requirements for adverse determination notifications.**

1. Except for the adverse determinations described in paragraph 2. of this subsection E., a notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:
  - a. An explanation of the specific medical basis for the adverse determination;
  - b. The specific reason or reasons for the adverse determination;
  - c. Reference to the specific plan provisions on which the determination is based;
  - d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;
  - e. If the carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

- f. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;
  - g. If applicable, instructions for requesting:
    - (1) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in subparagraph e. of this paragraph; or
    - (2) The written statement of the scientific or clinical rationale for the adverse determination, as provided in subparagraph f. of this paragraph; and
  - h. A description of the carrier's review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision.
- 2. For denials based on a contractual exclusion, the adverse determination notice shall advise the covered person of the right to appeal the applicability of the exclusion by providing evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply.
- 3. A carrier shall provide the notice required under this section in writing, either on paper or electronically.
- 4. All written adverse determinations, except an adverse determination described in § 10-16-113(1)(b)(I)(C) and (E), C.R.S., or adverse determinations described in Section 6(C) herein, must be signed by a licensed physician familiar with standards of care in Colorado. In the case of written denials of requests for covered benefits for dental care, a licensed dentist familiar with standards of care in Colorado may sign the written denial.
- 5. The notice of the initial adverse determination must include information concerning the covered person's ability to request an internal and external expedited review on a concurrent basis. This information may be included in the letter or other notice advising the covered person of the finding of an adverse determination, or it may be included as a separate document within the same mailing.

## **Section 7      Expedited Utilization Review**

### **A.      Procedures.**

- 1. A carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons and for making and notifying covered persons of expedited utilization review with respect to urgent care requests. For purposes of this section, "covered person" includes the designated representative of a covered person.
- 2. Notification requirements.
  - a. As part of the procedures required under paragraph 1., a carrier shall provide that, in the case of a failure by a covered person to follow the carrier's procedures for filing an urgent care request, the covered person shall be notified of the failure and the proper procedures to be following for filing the request.

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- b. The notice required under subparagraph a. of this paragraph:
    - (1) Shall be provided to the covered person as soon as possible but not later than twenty-four (24) hours after receipt of the request; and
    - (2) Shall be in writing.
  - c. The provisions of this paragraph apply only in the case of a failure that:
    - (1) Is a communication by a covered person that is received by a person or organizational unit of the carrier responsible for handling benefit matters; and
    - (2) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested.
- B. Urgent care requests.
- 1. Notification requirements for carrier determinations.
    - a. For an urgent care request, unless the covered person has failed to provide sufficient information for the carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the carrier's health coverage plan, the carrier shall notify the covered person and the covered person's provider of the carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two (72) hours after the receipt of the request by the carrier.
    - b. If the carrier's determination is an adverse determination, the carrier shall provide notice of the adverse determination in accordance with subsection E.
  - 2. Notification requirements for insufficient information.
    - a. If the covered person has failed to provide sufficient information for the carrier to make a determination, the carrier shall notify the covered person either orally or, if requested by the covered person, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four (24) hours after receipt of the request.
    - b. The carrier shall provide the covered person a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person of the failure to submit sufficient information, as provided in subparagraph a. of this paragraph.
    - c. The carrier shall notify the covered person and the covered person's provider of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight (48) hours after the earlier of:
      - (1) The carrier's receipt of the requested specified information; or

- (2) The end of the period provided for the covered person to submit the requested specified information.
  - d. If the covered person fails to submit the information before the end of the period of the extension, as specified in subparagraph b. of this paragraph, the carrier may deny the authorization of the requested benefit.
  - e. If the carrier's determination is an adverse determination, the carrier shall provide notice of the adverse determination in accordance with subsection E.
- C. Concurrent urgent care review requests.
  - 1. For concurrent review urgent care requests involving a request by the covered person to extend the course of treatment beyond the initial period of time or the number of treatments authorized, if the request is made at least twenty-four (24) hours prior to the expiration of the authorized period of time or authorized number of treatments, the carrier shall make a determination with respect to the request and notify the covered person and the covered person's provider of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four (24) hours after the carrier's receipt of the request.
  - 2. If the carrier's determination is an adverse determination, the carrier shall provide notice of the adverse determination in accordance with subsection E.
- D. For purposes of calculating the time periods within which a determination is required to be made under subsection B. or C., the time period within which the determination is required to be made shall begin on the date the request is received by the carrier in accordance with the carrier's procedures established for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.
- E. Adverse determination notification requirements.
  - 1. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:
    - a. An explanation of the specific medical basis for the adverse determination;
    - b. The specific reasons or reasons for the adverse determination;
    - c. Reference to the specific plan provisions on which the determination is based;
    - d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary;
    - e. If the carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

- f. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;
    - g. If applicable, instructions for requesting:
      - (1) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in subparagraph e. of this paragraph; or
      - (2) The written statement of the scientific or clinical rationale for the adverse determination, as provided in subparagraph f. of this paragraph; and
    - h. A description of the carrier's expedited review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision.
  - 2. Additional notification requirements.
    - a. A carrier may provide the notice required under this section orally, in writing or electronically.
    - b. If notice of the adverse determination is provided orally, the carrier shall provide written or electronic notice of the adverse determination within three (3) calendar days following the oral notification.
  - 3. All written adverse determinations must be signed by a licensed physician familiar with standards of care in Colorado. In the case of written denials of requests for covered benefits for dental care, a licensed dentist familiar with standards of care in Colorado may sign the written denial.
  - 4. The notice of the initial adverse determination must include information concerning the covered person's ability to request an internal and external expedited review on a concurrent basis. This information may be included in the letter or other notice advising the covered person of the finding of an adverse determination, or it may be included as a separate document within the same mailing.
- F. The requirements of section 7 apply to all written requests involving utilization review received by the carrier which are submitted by a covered person, the covered person's designated representative, or provider requesting a determination of coverage for a specific health care service or treatment for a specific member.

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**Section 8      Emergency Services**

- A. A carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed. Under these same circumstances, a claim for emergency services necessary to screen and stabilize a covered person shall not be denied for failure by the covered person or the emergency service provider to secure prior authorization. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider.
- B. Health maintenance organizations shall also comply with the life or limb threatening emergency coverage provisions of § 10-16-407(2), C.R.S., in reviewing claims for emergency services necessary to screen and stabilize a covered person.

**Section 9      Peer-to-Peer Conversation**

- A. In a case involving a prospective review determination, a carrier shall give the provider rendering the service an opportunity to request on behalf of the covered person a peer-to-peer conversation regarding an adverse determination by the reviewer making the adverse determination. Such a request may be made either orally or in writing.
- B. The peer-to-peer conversation shall occur within five (5) calendar days of the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination cannot be available within five (5) calendar days.
- C. If the peer-to-peer conversation does not resolve the difference of opinion, the adverse determination may be appealed by the covered person. A peer-to-peer conversation is not a prerequisite to a first level review or an expedited review of an adverse determination.
- D. For the purposes of § 10-3-1104(1)(i), C.R.S., a request for a peer-to-peer conversation shall not be considered a complaint.

**Section 10      First Level Review**

- A. A carrier shall establish written procedures for the review of an adverse determination that does not involve an urgent care request. The procedures shall specify whether a first level review request must be in writing or may be submitted orally. The procedures shall also allow the covered person to identify providers to whom the carrier shall send a copy of the review decision.
- B. A first level review shall be available to, and may be initiated by, the covered person. For purposes of this section, "covered person" includes the designated representative of a covered person.
- C. Pursuant to § 10-3-1104(1)(i), C.R.S., all written requests for a first level review must be entered into the carrier's complaint record.



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- D. Within 180 calendar days after the date of receipt of a notice of an adverse determination sent pursuant to section 6 or 7 or after the receipt of notification of a benefit denied due to a contractual exclusion, a covered person may file a grievance with the carrier requesting a first level review of the adverse determination. In order to secure a first level review after the receipt of the notification of a benefit denied due to a contractual exclusion, the covered person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply. If the deadline for filing a request ends on a weekend or holiday, the deadline shall be extended to the next business day.
- E. Conduct of first level reviews.
1. First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.
  2. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination. If the appeal is pursuant to § 10-16-113(1)(c), C.R.S., regarding the applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.
- F. Covered person's rights.
1. Individual health coverage plans.
    - a. A covered person is entitled to:
      - (1) Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review.

For review of a benefit denial due to a contractual exclusion, the covered person shall provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply; and
      - (2) Receive from the carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits. A document, record or other information shall be considered "relevant" to a covered person's request for benefits if the document, record or other information:
        - (a) Was relied upon in making the benefit determination;
        - (b) Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;

- (c) Demonstrates that, in making the benefit determination, the carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or
    - (d) Constitutes a statement of policy or guidance with respect to the health coverage plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.
  - b. A covered person has the right to be present for the appeal review, to bring counsel, advocates and health care professionals to the review, prepare in advance for the review, and present materials to the physician or dentist prior to the review and at the time of the review. The covered person is entitled to a single internal appeal review.
- 2. Group health coverage plans.

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

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

For review of a benefit denial due to a contractual exclusion, the covered person shall provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply; and
  - b. Receive from the carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits. A document, record or other information shall be considered "relevant" to a covered person's request for benefits if the document, record or other information:
    - (1) Was relied upon in making the benefit determination;
    - (2) Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;
    - (3) Demonstrates that, in making the benefit determination, the carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or
    - (4) Constitutes a statement of policy or guidance with respect to the health coverage plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

- G. Notification requirements.
1. A carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in subparagraph 2. or 3.
  2. With respect to a request for a first level review of an adverse determination involving a prospective review request, the carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) calendar days after the date of the carrier's receipt of the grievance requesting the first level review.
  3. With respect to a request for a first level review of an adverse determination involving a retrospective review request, the carrier shall notify and issue a decision within a reasonable period of time, but no later than thirty (30) calendar days after the date of the carrier's receipt of a request for the first level review.
- H. For purposes of calculating the time periods within which a determination is required to be made and notice provided under paragraph 3., the time period shall begin on the date the grievance requesting the review is received by the carrier in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.
- I. The decision issued pursuant to paragraph 3. shall set forth in a manner calculated to be understood by the covered person:
1. The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers".);
  2. A statement of the reviewers' understanding of the covered person's request for a review of an adverse determination;
  3. The reviewers' decision in clear terms; and
  4. A reference to the evidence or documentation used as the basis for the decision.
- J. A first level review decision involving an adverse determination issued pursuant to paragraph 3. shall include, in addition to the requirements of paragraph 5:
1. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;
  2. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in subsection F.2., to the covered person's benefit request;
  3. If the reviewers relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

4. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and
5. If applicable, instructions for requesting:
  - a. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in paragraph 3. of this subsection; and
  - b. The written statement of the scientific or clinical rationale for the determination, as provided in paragraph 4. of this subsection.
6. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to Section 5 of Colorado Insurance Regulation 4-2-21.
7. For group coverage plans, a description of the process to obtain a voluntary second level review, including:
  - a. The written procedures governing the voluntary second level review, including any required time frames for the review;
  - b. The right of the covered person to:
    - (1) Request the opportunity to appear in person before a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, who have appropriate expertise, who were not previously involved in the appeal, and who do not have a direct financial interest in the outcome of the review;
    - (2) Receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable;
    - (3) Present written comments, documents, records and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting;
      - (a) A copy of the materials the covered person plans to present or have presented on his or her behalf at the review should be provided to the health carrier at least five (5) calendar days prior to the date of the review meeting.
      - (b) Any new material developed after the five-day deadline shall be provided to the carrier when practicable;
    - (4) Present the covered person's case to the reviewer or review panel;
    - (5) If applicable, ask questions of the reviewer or review panel; and

- (6) Be assisted or represented by an individual of the covered person's choice, including counsel, advocates, and health care professionals;
- c. A statement that the carrier will provide the covered person, upon request, sufficient information relating to the voluntary second level review to enable the covered person to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process for selecting the decision maker, and the impartiality of the decision maker.
- d. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to Section 5 of Colorado Insurance Regulation 4-2-21 if the covered person chooses not to file for a voluntary second level review of the first level review decision involving an adverse determination.

**Section 11      General Requirements for First Level Review Meetings and Voluntary Second Level Review Meetings**

- A. A carrier shall establish a review process at which the covered person has the right to appear in person or by telephone conference at the review meeting before a health care professional (reviewer) or, if offered by the carrier, a review panel of health care professionals, selected by the carrier. The procedures shall allow the covered person to identify providers to whom the carrier shall send a copy of the review decision. The purpose of the review meeting process is to give the covered person the opportunity to explain his or her grievance and to provide any relevant evidence in support of his or her claim for benefits.
- B. For purposes of this section, "covered person" includes the designated representative of a covered person.
- C. A complaint record entry shall be made for all voluntary second level reviews, pursuant to §10-3-1104(1)(i), C.R.S.
- D. Covered Person's Review Request Filing Requirements.
  - 1. For individual coverage plans, the requirements of Section 10.D. apply.
  - 2. For group health coverage plans, within thirty (30) calendar days after the date of receipt of a notice of a first level review adverse determination, a covered person may file a request with the carrier requesting a voluntary second level review of the adverse determination. If the deadline for filing a request ends on a weekend or holiday, the deadline shall be extended to the next business day.
- E. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.
- F. Carrier's Requirements.
  - 1. The adverse determination, or with respect to a voluntary second level review of a first level review decision, the denial shall be reviewed by a health care professional (reviewer) or, if offered by the carrier, a review panel of health care professionals, who have appropriate expertise in relation to the case presented by the covered person.

2. The reviewer or review panel, shall meet the following criteria:
    - a. Were not previously involved in the appeal, and
    - b. Who do not have a direct financial interest in the appeal or outcome of the review.
  3. The reviewer or the review panel shall have the legal authority to bind the carrier to the reviewer's or review panel's decision.
- G. A carrier's procedures for conducting a review meeting shall include the following:
1. The reviewer or review panel shall schedule and hold a review meeting within sixty (60) calendar days of receiving a request from a covered person for a review meeting. The covered person shall be notified in writing at least twenty (20) calendar days in advance of the review date. The carrier shall not unreasonably deny a request for postponement of the review made by a covered person.
  2. Notice requirements. The notice to the covered person of the review date shall include:
    - a. The right of the covered person to present written comments, documents, records and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting.
    - b. The right of the covered person to receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable.
    - c. The responsibility of the covered person to submit a copy of the materials that the covered person plans to present or have presented on his or her behalf at the review to the carrier at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided to the carrier when practicable.
    - d. The responsibility of the covered person to, within seven (7) calendar days in advance of the review, inform the carrier if the covered person intends to have an attorney present to represent such person's interests. If the covered person decides to have an attorney present after the seven-day deadline, notice will be provided to the carrier when practicable.
    - e. The carrier shall use this notification to advise the covered person if it intends to have an attorney present to represent the interests of the carrier.
    - f. The carrier shall use this notification to advise the covered person that the plan shall make an audio or video recording of the review unless neither the covered person nor the carrier wants the recording made. The notice shall advise that this recording shall be made available to the covered person and that if there is an external review, the audio or video recording shall, at the request of either party, be included in the material provided by the carrier to the reviewing entity.

3. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. Whenever a covered person has requested the opportunity to appear in person, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a carrier shall offer the covered person the opportunity to communicate, at the carrier's expense, by telephone conference call. A carrier may also offer video conferencing or other appropriate technology.
  4. In conducting the review, if applicable, the reviewer or review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the covered person pursuant to Section 10.F.7.b., without regard to whether the information was submitted or considered in reaching the first level review decision. If the appeal is pursuant to § 10-16-113(1)(c), C.R.S., regarding the applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.
  5. The reviewer or review panel shall issue a written decision, as provided in subsection H., to the covered person within seven (7) calendar days of completing the review meeting.
  6. For purposes of calculating the time periods within which a decision is required to be made and notice provided, the time period shall begin on the date the request for a review meeting is received by the carrier in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.
- H. A decision issued pursuant to subsection G. shall include:
1. The name(s), title(s) and qualifying credentials of the reviewer or members of the review panel;
  2. A statement of the reviewer's or the review panel's understanding of the covered person's request for review of an adverse determination;
  3. The reviewer's or the review panel's decision in clear terms;
  4. A reference to the evidence or documentation used as the basis for the decision;
  5. For a decision issued involving an adverse determination:
    - a. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;
    - b. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in section 10.F.1.a.(2), to the covered person's benefit request;
    - c. If the reviewer or review panel has relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

- d. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and
- e. If applicable, instructions for requesting:
  - (1) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in subparagraph c. of this paragraph; and
  - (2) The written statement of the scientific or clinical rationale for the determination, as provided in subparagraph d. of this paragraph;
- f. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to Section 5 of Colorado Insurance Regulation 4-2-21.

## **Section 12 Expedited Review of an Adverse Determination**

- A. A carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination. A carrier shall also provide an expedited review to a request for a benefit for a covered person who has received emergency services but has not been discharged from a facility. The procedures shall allow a covered person to request an expedited review under this section orally or in writing. The procedures shall also allow the covered person to identify providers to whom the carrier shall send a copy of the review decision. Pursuant to § 10-16-113.5(7), C.R.S., a covered person requesting an expedited external review may request such review concurrently with a request for an expedited internal review.
- B. An expedited review shall be available to, and may be initiated by, the covered person or the provider acting on behalf of the covered person. For purposes of this section, "covered person" includes the designated representative of a covered person.
- C. Pursuant to § 10-3-1104(1)(i), C.R.S., all written requests for an expedited review must be entered into the carrier's complaint record.
- D. Expedited appeal evaluations.
  - 1. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case under review. (For the purposes of this section, the clinical peers shall be called "the reviewers".) The clinical peer or peers shall not have been involved in the initial adverse determination.
  - 2. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination.
- E. Covered person's rights.

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



1. Submit written comments, documents, records and other materials relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and
  2. Receive from the carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits, as described in section 10.F.1.a.
- F. In an expedited review, all necessary information, including the carrier's decision, shall be transmitted between the carrier and the covered person or the provider acting on behalf of the covered person by telephone, facsimile or similar expeditious method available.
- G. In an expedited review, a carrier shall make a decision and notify the covered person or the provider acting on the covered person's behalf as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the review is commenced. If the expedited review is a concurrent review determination, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.
- H. A carrier shall provide written confirmation of its decision concerning an expedited review within three (3) calendar days of providing notification of that decision, if the initial notification was not in writing.
- I. In the case of an adverse determination, the written decision shall contain the provisions specified in sections 10.I. and 10.J. of this regulation.
- J. For purposes of calculating the time periods within which a decision is required to be made under subsection G., the time period within which the decision is required to be made shall begin on the date the request is received by the carrier in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.
- K. In any case where the expedited review process does not resolve a difference of opinion between the carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may request an independent external review.
- L. A carrier shall not provide an expedited review for retrospective adverse determinations.

### **Section 13      Rescission and Initial Eligibility Determinations**

- A. The rescission of coverage and denials of coverage to an individual based on initial eligibility determinations are considered adverse determinations for the purposes of this regulation.
- B. A carrier shall provide notice thirty (30) calendar days in advance of the policy rescission to each covered person in the policy.
- C. An individual has the right to appeal a rescission or denial of coverage based on an initial coverage determination in accordance with Sections 10 and 11 of this regulation. However, a physician or panel of health care professionals is not required to evaluate these appeals or consult with an appropriate clinical peer pursuant to § 10-16-113(4)(b)(II), C.R.S.
- D. The carrier's rescission notification or denial of coverage based on an initial coverage determination do not have to be signed by a physician.

**Section 14 Severability**

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

**Section 15 Enforcement**

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

**Section 16 Effective Date**

This amended regulation is effective on December 1, 2013.

**Section 17 History**

Originally promulgated effective July 1, 1997.

Amended effective April 1, 2000.

Amended effective April 1, 2004 to comply with ERISA claims/appeals procedures.

Amended effective October 1, 2004, to correct internal references and to provide clarification with respect to the expedited appeal.

Emergency Regulation 05-E-5 effective January 1, 2006.

Amended effective February 1, 2006.

Amended regulation effective November 1, 2010.

Amended regulation effective December 1, 2013.

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

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

**Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, C.R.S., and 10-16-118(1)(b), C.R.S. (2012).

**Section 2 Scope and Purpose**

The purpose of this regulation is to establish the method grandfathered health benefit plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by § 10-16-118(1)(b), C.R.S. (2012).

**Section 3      Applicability**

This amended regulation shall apply to all certificates of creditable coverage issued on or after January 1, 2014.

**Section 4      Definitions**

- A.      "Individual", as used in this regulation, means a person age nineteen years and older.
- B.      "Grandfathered health benefit plan" shall have the same meaning as found at §10-16-102(31), C.R.S.
- C.      "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance (Division), a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Division, a significant break in coverage may consist of as few as sixty-three (63) days.

**Section 5      Rules**

- A.      Application of federal laws concerning creditable coverage.
  - 1.      The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by § 10-16-118(1)(b), C.R.S. (2012), shall be as set forth in the federal regulations incorporated by reference into this regulation.
  - 2.      Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.
- B.      Colorado law concerning creditable coverage.
  - 1.      The method for crediting and certifying creditable coverage described in this regulation shall apply to both group and individual grandfathered health benefit plans that are subject to § 10-16-118(1)(b), C.R.S. (2012)
  - 2.      Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.
  - 3.      Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the grandfathered health benefit plan that has the pre-existing condition exclusion will determine which break rule applies.
  - 4.      Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Division must issue certificates of creditable coverage that reflect the definition of a "significant break in coverage" found in section 4.C. of this regulation.

C. Pre-existing condition exclusion period for group health benefit plans.

Colorado law prohibits grandfathered group health benefit plans from imposing a pre-existing condition limitation period.

## **Section 6 Severability**

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

## **Section 7 Incorporated Materials**

45 CFR § 146.115 published by the Government Printing Office shall mean 45 CFR § 146.115 as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 146.115. A copy of 45 CFR § 146.115 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A Certified copy of the 45 CFR § 146.115 may be requested from the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at [www.ecfr.gov](http://www.ecfr.gov).

45 CFR § 148.124(b) published by the Government Printing Office shall mean 45 CFR § 148.124(b) as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 148.124(b). A copy of 45 CFR § 148.124(b) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A Certified copy of the 45 CFR § 148.124(b) may be requested from the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at [www.ecfr.gov](http://www.ecfr.gov).

## **Section 8 Enforcement**

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

## **Section 9 Effective Date**

This amended regulation is effective on January 1, 2014.

## **Section 10 History**

Originally issued as Emergency Regulation 97-E-6, effective July 31, 1997.  
Issued as Regulation 4-2-18, effective October 30, 1997.  
Amended, effective November 1, 1999.  
Amended, effective October 1, 2004.  
Amended regulation effective March 1, 2012.  
Amended regulation effective January 1, 2014.

**Regulation 4-2-19      CONCERNING INDIVIDUAL HEALTH BENEFIT PLANS TO SELF-EMPLOYED  
BUSINESS GROUPS OF ONE [Repealed eff. 01/01/2014]**

**Regulation 4-2-20      CONCERNING THE COLORADO SUPPLEMENT TO THE SUMMARY OF  
BENEFITS AND COVERAGE FORM**

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

**Section 1      Authority**

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

**Section 2      Scope and Purpose**

The purpose of this regulation is to coordinate the requirements of § 10-16-108.5(11), C.R.S. and certain provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA). This regulation also sets out procedures for carriers to make available a Colorado Supplement to the Summary of Benefits and Coverage Form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer.

**Section 3      Applicability**

This regulation shall apply to all carriers offering or providing health benefit plans.

**Section 4      Definitions**

- A. "Carrier" shall have the same meaning as found § 10-16-102(8), C.R.S.
- B. "Glossary" means the form required by the Affordable Care Act as described in the final rule published on February 14, 2012 in Volume 77, No. 30 of the Federal Register (77 FR 8668, Summary of Benefits and Coverage and Uniform Glossary).
- C. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- D. "Summary of Benefits and Coverage" means the form required by the Affordable Care Act as described in the final rule published on February 14, 2012 in Volume 77, No. 30 of the Federal Register (77 FR 8668, Summary of Benefits and Coverage and Uniform Glossary).

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**Section 5        Rules**

- A. All carriers offering or providing health benefit plan coverage shall make available to a producer or consumer through electronic means or paper copy, along with a Summary of Benefits and Coverage form, a completed copy of the Colorado Supplement to the Summary of Benefits and Coverage Form shown in Appendix A for each policy or contract for a health benefit plan that either covers a Colorado resident or is selected by a Colorado resident or such resident's employer for which the employee or participant is eligible.
- B. Carriers shall use the exact format found in Appendix A for the Colorado Supplement to the Summary of Benefits and Coverage Form. All boxes must be filled in. Carriers may modify box dimensions, reduce margins, or use a portrait rather than a landscape page layout format. A carrier may also add its logo and form number to the form and print the form in color or black and white. Pursuant to § 10-3-1104(1), C.R.S., in completing the form, carriers shall not misrepresent the benefits, advantages, conditions, or terms of the policy.
- C. Carriers shall follow the directions for completing the Colorado Supplement to the Summary of Benefits and Coverage Form found in Appendix B of this regulation.
- D. Carriers shall provide a Colorado Supplement to the Summary of Benefits and Coverage Form that is specific with respect to the particular policy provisions of the policy as follows:
1. Automatically, along with the applicable Summary of Benefits and Coverage form, other health benefit plan description materials, or enrollment application given to employees or members of a group, association or health care cooperative who have the option of selecting such an employer-sponsored, group-sponsored, association-sponsored, or cooperative-sponsored plan when they initially become eligible for coverage and thereafter during any open enrollment period;
  2. Automatically, along with the applicable Summary of Benefits and Coverage form within seven (7) business days of a potential policyholder expressing interest in a particular plan or such plan being selected as a finalist from which the ultimate selection will be made;
  3. Upon request, along with the applicable Summary of Benefits and Coverage form, and the glossary if requested, within seven (7) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier. The request may be made orally or in writing to the carrier;
  4. Upon request, along with the applicable Summary of Benefits and Coverage form, and the glossary if requested, within seven (7) business days to a producer on behalf of any person, group, association, or health care cooperative that is interested in coverage or is covered by a health benefit plan of the carrier. The request may be made orally or in writing to the carrier;
  5. As part of any written application materials that are distributed by the carrier for enrollment, along with the applicable Summary of Benefits and Coverage form. If written application materials are not distributed, it shall be provided no later than the first date on which the employee is eligible to enroll for coverage for the employee or dependent;
  6. No later than thirty (30) calendar days prior to the first day of coverage under the new plan year when the policy has an automatic renewal, along with the applicable Summary of Benefits and Coverage form. If the policy has not been issued or renewed before such 30-day period, it should be provided no later than seven (7) business days after issuance of the new policy or the receipt of written confirmation of intent to renew whichever is earlier;

7. As soon as practicable following the receipt of the group application, but in no event later than seven (7) business days following receipt of the application, along with the applicable Summary of Benefits and Coverage form;
  8. If there is any change in the information required to be on the Colorado Supplement to the Summary of Benefits and Coverage Form between the application for coverage and the first day of coverage, the carrier must update and provide a current form to the individual, employee and/or dependent no later than the first day of coverage.
- E. Anti-duplication rule.
1. For group plans, if the employer, plan administrator, association or health care cooperative has provided the required form to the employee, dependent or member, the carrier is not required to provide a duplicate Colorado Supplement to the Summary of Benefits and Coverage Form.
  2. For individual policies, the Colorado Supplement to the Summary of Benefits and Coverage Form may be provided to one address unless any dependents are known to reside at a different address.
- F. A carrier shall develop a separate Colorado Supplement to the Summary of Benefits and Coverage Form for each of its health benefit plans.
- G. The Colorado Supplement to the Summary of Benefits and Coverage Form should not include attachments, except that a carrier may:
1. Attach a list of exclusions developed pursuant to subsection H. of section 5 of this regulation;
  2. Attach information on premiums;
  3. Attach information on riders; or
  4. Include at the end of the form, or as an attachment, information that is statutorily required of marketing materials (e.g., for managed care plans, disclosure of the existence and availability of an access plan, as required pursuant to § 10-16-704(9), C.R.S.).
- H. A carrier shall make a list of policy exclusions available immediately upon request, but in no event more than seven (7) business days after the request, for each of its health benefit plans.
- I. The Colorado Supplement to the Summary of Benefits and Coverage Forms developed for each health benefit plan shall be in standard, easy-to-read type sizes and fonts, of no less than 12 points.
- J. Required notices in a culturally and linguistically appropriate manner for individual and group health benefit plans.

Carriers that have service areas which include a county where 10% or more of the population are only literate in the same non-English language must meet the following requirements for both the Summary of Benefits and Coverage form and the Colorado Supplement to the Summary of Benefits and Coverage form:

1. Include on each English version of the form, a statement prominently displayed in the non-English language, offering to provide, upon request, a fully-translated version of these notices in the non-English language and which clearly indicates how to access the language services provided by the carrier; and
2. Once a request has been made by an individual, provide all subsequent forms to the policyholder in the non-English language.

#### **Section 6 Severability**

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

#### **Section 7 Incorporated Materials**

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

#### **Section 8 Enforcement**

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

#### **Section 9 Effective Date**

This regulation is effective on November 1, 2013.

#### **Section 10 History**

New regulation effective November 15, 1997.  
Amended Sections 1, 2, 3, 4, 7, Appendix A, and Appendix B effective September 30, 1998.  
Amended regulation effective January 1, 2004.  
Amended regulation effective: January 1, 2005.  
Amended regulation effective July 1, 2007.  
Repealed and repromulgated effective September 1, 2012.  
Amended regulation effective November 1, 2013.

#### **Appendix A**

##### **Colorado Supplement to the Summary of Benefits and Coverage Form**

\_\_\_\_\_  
Name of Carrier

\_\_\_\_\_  
Name of Plan

\_\_\_\_\_  
Policy Type



#### TYPE OF COVERAGE

1. Type of plan.	
2. Out-of-network care covered? <sup>1</sup>	
3. Areas of Colorado where plan is available.	

#### SUPPLEMENTAL INFORMATION REGARDING BENEFITS

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

	Description	What this means.
4. Deductible Period	[Calendar year]	[Calendar year deductibles restart each January 1.]
	[Benefit year]	[Benefit year deductibles restart on a date other than January 1. Please see your policy or plan document to see the date the deductible starts over.]
	[Per Accident or Sickness]	[Deductible restarts with each new accident and/or sickness. Please see your policy or plan document for a more complete description.]
5. Annual Deductible Type	[Individual/Family]	["Individual" means the deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover those expenses."Family" is the maximum deductible amount that is required to be met for all family members covered by the plan. It may be an aggregated amount (e.g., "\$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family").]
	[Single Coverage/Non-single Coverage]	["Single" means the deductible amount you will have to pay for allowable covered expenses under this HSA-qualified health plan when you are the only individual covered by the plan. "Non-single" is the deductible amount that must be met by one or more family members covered by this HSA-qualified plan before <u>any</u> covered expenses are paid.]
6. What cancer screenings are covered?		

#### LIMITATIONS AND EXCLUSIONS

7. Period during which pre-existing conditions are not covered for covered persons age 19 and older. <sup>2</sup>	
8. How does the policy define a "pre-existing condition"?	
9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	

**USING THE PLAN**

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

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

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

Colorado Division of Insurance  
Consumer Affairs Section  
1560 Broadway, Suite 850, Denver, CO 80202  
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)  
Email: [insurance@dora.state.co.us](mailto:insurance@dora.state.co.us)

**Endnotes**

- 1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that this plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
- 2 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

**Appendix B**

**Directions for Filling Out the  
Colorado Supplement to the Summary of Benefits and Coverage Form**

**TOP OF FORM**

Carrier and plan names: Fill in the complete carrier name on the first line and the name of the plan on the second line. Carriers may also include the following information, if they wish to do so, either at the top of the form, at the bottom of the page, or at the end of the document: carrier logo, group identification number, class or division, and effective date.

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

**TYPE OF COVERAGE**

Question 1: Type of Plan. Enter type of plan. Select one of the following choices only: (1) "Medical expense policy", (2) "Preferred provider organization (PPO)", (3) "Health maintenance organization (HMO)", (4) "Point of service (POS)" (i.e., an HMO plan with some out-of-network benefits), or (5) "Limited service licensed provider network (LSLPN) plan".

Question 2: Coverage for Out-of-Network Care. Indicate if out-of-network care is covered. Select one of the following choices only: (1) "Only for emergency care"; (2) "Only for emergency and urgent care"; (3) "Only for specified services; patient pays more for such out-of-network care" [e.g., POS plans]; (4) "Yes, but patient pays more for out-of-network care." [e.g., PPO]; or (5) "Yes; plan makes no distinction between in-network and out-of-network care." [e.g., traditional indemnity plans]. For HMOs that are marketing to small employers or employees of small employers outside of its geographic service area, the following statement must be added in bold, 10 point font caps:

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

Question 3: Where Plan Is Available. Indicate where the plan itself is available. This question does not concern the residence of the potential enrollee. Select one of the following choices only: (1) "Plan is available throughout Colorado"; (2) "Plan is available only in the following areas: [fill in]"; or (3) "Plan is available throughout Colorado except in the following areas: [fill in]." A note should be added if the plan is marketed to employers or employees located over state or county lines.

### **SUPPLEMENTAL INFORMATION REGARDING BENEFITS**

Question 4: Deductible Period. Describe whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Sickness".

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

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

### **LIMITATIONS AND EXCLUSIONS**

Question 7: Pre-existing Condition Exclusion Period for covered persons age 19 and older. Select one of the following choices only: (1) "\_\_\_\_ [insert the length of the limitation period] months for all pre-existing conditions."; (2) "\_\_\_\_ [insert the length of the limitation period] months for selected pre-existing conditions only; no pre-existing condition limitation for all other conditions. See policy for details."; (3) "Not applicable; plan does not impose limitation periods for pre-existing conditions."; (4) "This individual short-term health benefit plan does not cover pre-existing conditions."

Note: For group plans (except business groups of one) the limitation period may not exceed six (6) months; for business groups of one the limitation period may not exceed 12 months. Carriers are reminded that Colorado law governs allowable pre-existing periods for all health benefit plans.

Question 8: Definition of a Pre-existing Condition. Enter the definition of a pre-existing condition under this policy. Select one of the following choices only: (1) "Not applicable. Plan does not exclude coverage for pre-existing conditions."; (2) for group plans: "A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last \_\_\_\_ [insert a number not to exceed 12 for business groups of one and not to exceed 6 for all other group plans] months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on children under 19, special enrollees, or for pregnancy."; (3) for individual plans: "A pre-existing condition is an injury, sickness or pregnancy for which a person, 19 or older, incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within \_\_\_\_ [insert a number not to exceed 12] months immediately preceding the effective date of coverage."; or (4) for individual short-term health benefit plans: "A pre-existing condition is an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within \_\_\_\_ [insert a number not to exceed 12] months immediately preceding the effective date of coverage."

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

### **USING THE PLAN**

Question 10: General Directions. If the plan has separate in-network and out-of-network benefits, use two columns and label them "In-network" and "Out-of-network." If the plan does not make such a distinction (e.g., a traditional indemnity plan), replace two columns with a single column labeled "Using the Plan."

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

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

### **QUESTIONS' FOOTER**

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

### **Regulation 4-2-21 External Review of Benefit Denials of Health Coverage Plans**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Notice and Disclosure of Right to External Review
Section 6	Request for External Review
Section 7	Exhaustion of Internal Appeal Process
Section 8	Standard External Review
Section 9	Expedited External Review
Section 10	Binding Nature of External Review Decisions
Section 11	Approval of Independent External Review Entities
Section 12	Minimum Qualifications for Independent External Review Entities
Section 13	External Review Record Requirements
Section 14	Funding of External Review
Section 15	Severability
Section 16	Enforcement
Section 17	Effective Date
Section 18	History

## **Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-109, and 10-16-113.5(4)(d), C.R.S.

## **Section 2      Scope and Purpose**

The purpose of this regulation is to provide standards for the external review process set forth in § 10-16-113.5, C.R.S., including the approval of independent external review entities. It is being amended to facilitate the implementation of certain provisions of recently enacted HB 13-1266.

## **Section 3      Applicability**

The provisions of this regulation shall apply to all health coverage plans that base coverage decisions in whole or in part based on utilization reviews as defined in this regulation. This regulation shall not apply to automobile medical payment policies, worker's compensation policies or property and casualty contracts. Where a decision concerning a claim is in no way based on utilization review, a carrier is not required to use the specific procedures outlined in this regulation, except this regulation shall apply to a carrier's denial of a benefit because the treatment is excluded by the health coverage plan if the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply. This regulation also applies to carriers offering wellness and prevention programs that offer any incentive or reward for satisfying a standard related to a health risk factor. Nothing in this regulation shall be construed to supplant any appeal or due process rights that a person may have under federal or state law.

## **Section 4      Definitions**

- A. "Adverse determination" shall have the same meaning as found at § 10-16-113.5(2)(a), C.R.S., and shall include an adverse determination that, pursuant to Colorado Insurance Regulation 4-2-17, is eligible for an expedited external review to be conducted concurrently with an expedited internal appeal request. This definition shall also include a carrier's denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor.
- B. "Ambulatory review" means, for purposes of this regulation, a utilization review of health care services performed or provided in an outpatient setting.
- C. "Business day" means, for purposes of this regulation, the days of the week between and including Monday through Friday, not including public holidays and weekends.
- D. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- E. "Case management" means, for purposes of this regulation, a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.
- F. "Certification," as used in the definition of "utilization review," means, for purposes of this regulation, a determination by a carrier that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or efficiency.

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- G. "Clinical review criteria" means, for purposes of this regulation, the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a carrier to determine the necessity and appropriateness of health care services.
- H. "Concurrent review" means, for purposes of this regulation, a utilization review conducted during a patient's hospital stay or course of treatment.
- I. "Covered benefits" or "benefits," means, for purposes of this regulation, those health care services to which a covered person is entitled under the terms of a health coverage plan.
- J. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S. For the purposes of this regulation, "covered person" includes the covered person's designated representative.
- K. "De minimis" means, for the purposes of this regulation, any minor error or omission that does not substantively impact the rights of a covered person to request an external review of an adverse determination. The submission of a request on an incorrect form that contains all of the needed information is an example of a de minimis error. A carrier submitting a request to the Division in an untimely manner is not an example of a de minimis error.
- L. "Designated representative" means, for purposes of this regulation:
1. A person, including the treating health care professional or a person authorized by paragraph 2. of this subsection J., to whom a covered person has given express written consent to represent the covered person in an external review; or
  2. A person authorized by law to provide substituted consent for a covered person, including but not limited to a guardian, agent under a power of attorney, a proxy, or a designee of the Colorado Department of Health Care Policy and Financing (HCPF); or
  3. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.
- M. "Discharge planning" means, for purposes of this regulation, the formal process for determining, prior to discharge from a facility or service, the coordination and management of the care that a patient receives following discharge from a facility or service.
- N. "Disability" means, for purposes of this regulation, with respect to a covered person, a physical or mental impairment that substantially limits one or more of the major life activities of such covered person, in accordance with the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101.
- O. "Expedited review" shall have the same meaning as found at § 10-16-113.5(2)(c), C.R.S.
- P. "Facility" means, for purposes of this regulation, an institution providing health care services, or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- Q. "Health care professional" means, for purposes of this regulation, a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.
- R. "Health care services" shall have the same meaning as found at § 10-16-102(33), C.R.S.

- S. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.
- T. Medical and scientific evidence" shall have the same meaning as found at § 10-16-113.5(2)(h), C.R.S.
- U. "Prospective review" means, for purposes of this regulation, utilization review conducted prior to an admission or a course of treatment, also known as a "pre-service review".
- V. "Protected health information" means health information:
  - 1. That identifies an individual who is the subject of the information; or
  - 2. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.
- W. "Retrospective review" means, for purposes of this regulation, utilization review conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment, also known as a "post-service review".
- X. "Second opinion" means, for purposes of this regulation, an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the necessity and appropriateness of the initial proposed health service.
- Y. "Utilization review" means, for purposes of this regulation, a set of formal techniques designed to monitor the use of, or evaluate the necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

## **Section 5 Notice and Disclosure of Right to External Review**

- A. Notification requirements.
  - 1. A carrier shall notify the covered person in writing of the covered person's right to request an expedited internal and external review on a concurrent basis at the time the carrier sends written notice of the carrier's adverse determination following the covered person's urgent care request, as set forth in Colorado insurance regulation 4-2-17 Section 7. This information may be included in the written adverse determination notice itself, or it may be included as a separate document within the same mailing.
  - 2. At the completion or exhaustion of the first level review or at the completion of the voluntary second level review:
    - a. A carrier shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in subparagraph b. of this paragraph 1. at the time the carrier sends written notice of the carrier's adverse determination following the first level or voluntary second level review as set forth in Colorado Insurance Regulation 4-2-17.

- b. The carrier shall include in the required notice a copy of the description of both the standard and expedited external review procedures the carrier is required to provide pursuant to subsection B., including the provisions in the external review procedures that give the covered person the opportunity to submit new information and including any forms used to process an external review, as specified by the Division of Insurance (Division).
  - 3. Following the denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program, a carrier shall notify the covered person in writing of the covered person's right to request an external review, the procedures for making this request, and the timelines associated with an external review. These review requests are not eligible for the expedited external review process described in Section 9 of this regulation.
- B. Disclosure requirements.
  - 1. Each carrier shall include a description of the external review procedures in or attached to all health coverage plan materials dealing with the carrier's grievance procedures including but not limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.
  - 2. The description required under paragraph 1. of this subsection B. shall include a notification of the availability of an external review process, the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review.
  - 3. The description required under paragraph 1. of this subsection B. shall also include:
    - a. A notification of the covered person's ability to request a concurrent expedited external review when a request for an expedited internal review has been made; and
    - b. A notification that the carrier's failure to comply with any requirement of § § 10-16-113 and 10-16-113.5, C.R.S. or with any requirement of Colorado Insurance Regulation 4-2-17 or this regulation may deem the internal process exhausted and permit the covered person to request an independent external review.
- C. There is no minimum dollar amount for a claim to be eligible for an external review.

## **Section 6 Request for External Review**

- A. Within four (4) months after the date of receipt of a notice of a carrier's adverse determination following the completion or exhaustion of the internal appeal process pursuant to Colorado Insurance Regulation 4-2-17, a covered person may file a written request for an external review with the carrier. For purposes of this subsection A., the date of receipt shall be calculated to be no less than three (3) calendar days after the date the notice is postmarked by the carrier. If the deadline for filing a request ends on a weekend or holiday, the deadline shall be extended to the next business day.
- B. All requests for external review shall be made in writing to the carrier and must include a completed external review request form as specified by the Division.



- C. A request for an external review may be made if an adverse determination has been made involving a recommended or requested medical service that is experimental or investigational if the treating physician certifies that the recommended or requested health care service or treatment will be less effective if not begun immediately, and:
1. The treating physician certifies that standard health care services or treatments have not improved the condition of the covered person or are not medically appropriate for the covered person; or
  2. The treating physician certifies that there is no standard health care service or treatment available that is covered by the carrier that is more beneficial to the covered person than the recommended or requested health care service or treatment, and that the physician is a board-certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition.
- The physician must also certify that scientifically valid studies support the health care service or treatment subject to denial is likely to be more beneficial to the covered person than any available standard health care services or treatments.
- D. A covered person requesting an expedited external review must include a request for an expedited review in the written request described in subsection A. and B. of this section 6.
- E. All requests for external review shall include a signed consent form, authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review.
- F. A request for external review submitted by the covered person may include new or additional information, if significantly different from information provided or considered during the internal appeals process, for consideration by the carrier and the independent external review entity.
- G. A carrier's denial of a request for a standard external review, including but not limited to a de minimis error, shall be made in writing and include the specific reasons for the denial and shall provide information about appealing the denial of the request with the Division. A copy of the denial shall be sent to the Division at the same time it is sent to the covered person.
- H. A carrier's denial of a request for an expedited external review, including but not limited to a de minimis error, shall be made in writing and transmitted electronically or by facsimile or any other available expeditious method. It must include the specific reasons for the denial and shall provide information about appealing the denial of the request with the Division. A copy of the denial must be sent to the Division at the same time it is sent to the covered person.

## **Section 7      Exhaustion of Internal Appeal Process**

- A. A request for an external review pursuant to Section 8 or 9 of this regulation may be made after the covered person has received the carrier's decision following the first level or voluntary second level review of an adverse determination as set forth in Colorado Insurance Regulation 4-2-17.
- B. A request for an external review pursuant to Section 8 or 9 of this regulation may be made if the carrier fails to comply with any of the requirements of Section 10 of Colorado Insurance Regulation 4-2-17.
- C. A request for an external review pursuant to Section 9 of this regulation may be made concurrent to an expedited request for a first level review in accordance with the requirements set forth in Colorado Insurance Regulation 4-2-17.

- D. A carrier's denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor is not subject to the internal appeal process requirements set forth in Colorado Insurance Regulation 4-2-17.

**Section 8      Standard External Review**

A. Carrier requirements.

1. Except as provided in paragraph 2. of this subsection A., the carrier, upon receipt of a complete request for an external review pursuant to Section 6 of this regulation, shall deliver a copy of the request to the Commissioner of Insurance within two (2) business days.
  - a. Whenever a carrier receives an incomplete standard request for external review that fails to meet the health carriers filing procedures, the carrier shall notify the covered person of this failure as soon as possible, but in no event later than five (5) days following the date the incomplete request was received.
  - b. Whenever a carrier receives an incomplete expedited request for external review that fails to meet the health carriers filing procedures, the carrier shall notify the covered person of this failure as soon as possible, but in no event later than twenty-four (24) hours after the incomplete request was received.
2. If the carrier, before the expiration of the deadline for sending notification to the Commissioner, reverses its adverse determination based on new or additional information submitted by the covered person pursuant to Section 6, subsection E., the carrier must notify the covered person within one (1) business day of its reversal, electronically, by facsimile, or by telephone followed by a written confirmation.

B. Division of Insurance requirements.

1. Within two (2) business days from the time a request for external review is received from the carrier, the Commissioner shall assign an independent external review entity to conduct the external review that has been approved pursuant to Section 11 of this regulation. The Commissioner shall randomly select an independent external review entity that does not have a conflict of interest, as described in Section 12. Upon assignment, the Commissioner shall notify the carrier, electronically or by facsimile, of the name and address of the independent external review entity to which the appeal should be sent.
2. After notice from the Commissioner pursuant to paragraph 1. of this subsection B., the carrier shall notify the covered person within one (1) business day electronically, by facsimile, or by telephone followed by a written confirmation. The notice shall include a written description of the independent external review entity that the Commissioner has selected to conduct the external review and information regarding how the covered person may provide the Commissioner with documentation regarding any potential conflict of interest of the independent external review entity as described in Section 12 of this regulation.

3. Within two (2) business days of receipt of notice from the carrier, the covered person may provide the Commissioner with documentation regarding a potential conflict of interest of the independent external review entity, electronically, by facsimile, or by telephone followed by a written confirmation. If the Commissioner determines that the independent external review entity presents a conflict of interest as described in § 10-16-113.5(4)(b), C.R.S., the Commissioner shall assign, within one (1) business day, a different independent external review entity to conduct the external review that has been approved pursuant to Section 11 of this regulation. Upon this reassignment, the Commissioner shall notify the carrier, electronically or by facsimile of the name and address of the new independent external review entity to which the appeal should be sent. The Commissioner will notify the covered person in writing of the Commissioner's determination regarding the potential conflict of interest, and the name and address of the new independent external review entity, if applicable.
  4. Within five (5) business days of receipt of the notice from the carrier, the covered person may provide additional information to the independent external review entity that shall be considered during the review. The independent external review organization is not required to, but may, accept and consider additional information submitted after five (5) business days. The independent external review organization shall forward this information to the carrier within one (1) business day of receipt.
  5. In reaching a decision, the independent external review entity is not bound by any decisions or conclusions reached during the carrier's utilization review process or the carrier's internal appeal process as set forth in Colorado Insurance Regulation 4-2-17.
- C. Carrier requirements to provide documents and information.
1. Within five (5) business days from the date the carrier receives notice from the Commissioner pursuant to paragraph 1. of Section 8.B., the carrier shall deliver to the assigned independent external review entity the following documents and information considered in making the carrier's adverse determination including:
    - a. Any and all information submitted to the carrier by a health care professional or the covered person in support of:
      - (1) The request for coverage under the health coverage plan's procedures; or
      - (2) The request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program;
    - b. Any and all information used by the carrier during the internal appeal process to determine the medical necessity, medical appropriateness, medical effectiveness, or medical efficiency of the proposed treatment or service, including medical and scientific evidence and clinical review criteria;
    - c. A copy of any and all denial letters issued by the carrier concerning the case under review;
    - d. A copy of the signed consent form, authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review; and
    - e. An index of all submitted documents.

2. Within two (2) business days of receipt of the material specified in paragraph 1. of this subsection C., the independent external review entity shall deliver to the covered person the index of all materials that the carrier has submitted to the independent external review entity. The carrier shall provide to the covered person, upon request, all relevant information supplied to the independent external review entity that is not confidential or privileged under state or federal law concerning the case under review.
  3. Independent external review entity notification requirements.
    - a. The independent external review entity shall notify the covered person, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to paragraph 1. of this subsection C. Within five (5) business days of such a request, the covered person or the health care professional of the covered person shall submit the additional information, or an explanation of why the additional information is not being submitted to the independent external review entity and the carrier.
    - b. If the covered person or the health care professional of the covered person fails to provide the additional information or the explanation of why additional information is not being submitted within the timeframe specified in subparagraph a. of this paragraph 3., the independent external review entity shall make a decision based on the information submitted by the carrier as required by paragraph 1. of this subsection C.
  4. Failure of the carrier to provide documents and information.
    - a. If the carrier fails to provide the required documents and information within the time specified in paragraph 1. of this subsection C., the independent external review entity may terminate the external review and make a decision to reverse the carrier's adverse determination.
    - b. Immediately upon the reversal under subparagraph a. of this paragraph 4., the independent external review entity shall notify the covered person, the carrier, and the Commissioner.
  5. Except as provided in paragraph 4. of this subsection C., failure by the carrier to provide the documents and information within the time specified in paragraph 1. of this subsection C. shall not delay the conduct of the external review.
- D. The independent external review entity shall review all of the information and documents received pursuant to subsection C. of this Section 8.
- E. Carrier's reconsideration of its adverse determination.
1. Upon receipt of the information permitted to be forwarded pursuant to Section 6.E. and subsection B.4. of this Section 8, the carrier may reconsider the adverse determination that is the subject of the external review.
  2. Consideration of new information by the carrier of its adverse determination pursuant to paragraph 1. of this subsection E. shall not delay or terminate the external review.

3. The external review may only be terminated if the carrier decides to reverse its adverse determination and provide coverage or payment for the health care service or, for the purposes of participation in a wellness and prevention program, grant the request for an alternate standard or waiver of a standard that is the subject of the carrier's adverse determination.
4. Carrier notification requirements of reversal of adverse determination.
  - a. Within one (1) business day of making the decision to reverse its adverse determination, as provided in paragraph 3., the carrier shall notify the covered person, the independent external review entity, and the Commissioner of its decision, electronically, by facsimile, or by telephone followed by a written confirmation.
  - b. The independent external review entity shall terminate the external review upon receipt of the notice from the carrier sent pursuant to subparagraph a. of this paragraph 4.
- F. In addition to the documents and information provided pursuant to subsection C. of this Section 8, the independent external review entity, to the extent the documents or information are available, shall review the following:
  1. The covered person's medical records;
  2. The attending health care professional's recommendation;
  3. Consulting reports from appropriate health care professionals and other documents submitted by the carrier, covered person, or the covered person's treating provider;
  4. Any applicable clinical review criteria developed and used by the carrier; and
  5. Medical and scientific evidence determined to be relevant and appropriate by the independent review entity.
- G. The independent external review entity shall base its determination on an objective review of relevant medical and scientific evidence.
- H. Independent external review entity notice requirements.
  1. Within forty-five (45) calendar days after the date of receipt of the request for external review, the independent external review entity shall:
    - a. Make a decision to uphold or reverse the carrier's adverse determination, in whole or in part; and
    - b. Provide a written notification of its decision to the following:
      - (1) The covered person;
      - (2) The carrier;
      - (3) The physician or other health care professional of the covered person; and
      - (4) The Commissioner.

2. In addition to the requirements of § 10-16-113.5(11), C.R.S., the independent external review entity shall include in the notice sent pursuant to paragraph 1. of this subsection H.:
  - a. The date the independent external review entity received the assignment from the Commissioner to conduct the external review;
  - b. The date of its decision; and
  - c. An explanation that the external review decision is the final appeal available to the consumer under state insurance law.
3. Upon the carrier's receipt of the independent external review entity's notice of a decision pursuant to paragraph 1. of this subsection H. reversing its adverse determination, the carrier shall approve the coverage or, for the purposes of participation in a wellness and prevention program, grant the requested alternate standard or waiver of the standard that was the subject of the carrier's adverse determination.
  - a. For concurrent and prospective reviews, the carrier shall approve the coverage within one (1) business day.
  - b. For retrospective reviews, the carrier shall approve the coverage within five (5) business days.
  - c. The carrier shall provide written notice of the approval to the covered person or the covered person's designated representative within one (1) business day of the carrier's approval of coverage.
  - d. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

## **Section 9      Expedited External Review**

### **A.      Request requirements.**

1. Except as provided in subsections H. and I. of this Section 9, a covered person may make a request for an expedited external review with the carrier if the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this regulation would seriously jeopardize the life or health of the covered person, would jeopardize the covered person's ability to regain maximum function or, for persons with a disability, create an imminent and substantial limitation of their existing ability to live independently.
2. The covered person's or the covered person's designated representative's request for an expedited review must include a physician's certification that the covered person's medical condition meets the criteria in paragraph 1. of this subsection A.
3. Upon receipt of a request for an external review and the physician's certification pursuant to paragraph 1. and paragraph 2. of this subsection A., the carrier shall notify and send a copy of the request to the Commissioner within one (1) business day electronically or by telephone or facsimile or any other available expeditious method.

- B. Division of Insurance requirements.
1. Within one (1) business day of the time the Commissioner receives a request for an expedited external review, the Commissioner shall randomly assign an independent external review entity that has been approved pursuant to Section 11 of this regulation to conduct the review and to make a decision regarding the carrier's adverse determination. The Commissioner shall select an independent external review entity that does not have a conflict of interest with the case, as described in Section 12. Upon assignment, the Commissioner shall inform the carrier of the name and address of the independent external review entity to which the appeal should be sent.
  2. Within one (1) business day of notice from the Commissioner pursuant to paragraph 1. of this subsection B., the carrier shall notify the covered person, electronically, by facsimile, or by telephone followed by a written confirmation. The notice shall include a written description of the independent external review entity that the Commissioner has selected to conduct the independent review.
- C. In reaching a decision, the independent external review entity is not bound by any decisions or conclusions reached during the carrier's utilization review process or the carrier's internal appeal process as set forth in Colorado Insurance Regulation 4-2-17.
- D. Immediately upon receipt of the notification pursuant to subsection B., the carrier shall provide or transmit all necessary documents and information, as described in Section 8.C.1., considered in making its adverse determination to the independent external review entity electronically or by telephone or facsimile or any other available expeditious method.
- E. In addition to the documents and information provided or transmitted pursuant to subsection D. of this Section 9, the independent external review entity, to the extent the information or documents are available, shall consider the following in reaching a decision:
1. The covered person's medical records;
  2. The attending health care professional's recommendation;
  3. Consulting reports from appropriate health care professionals and other documents submitted by the carrier, covered person, or the covered person's treating provider;
  4. Any applicable clinical review criteria developed and used by the carrier; and
  5. Documents and information regarding medical and scientific evidence, to the extent the independent review entity considers them appropriate.
- F. The independent external review entity shall base its determination on an objective review of relevant medical and scientific evidence.
- G. Independent external review entity notice requirements.
1. Notwithstanding the requirements of § 10-16-113.5(11), C.R.S., within seventy-two (72) hours after the receipt of the assignment of the request for external review, the independent external review entity shall:
    - a. Make a decision to uphold or reverse the carrier's adverse determination, in whole or in part; and
    - b. Provide a notification of the decision to the following:

- (1) The covered person;
  - (2) The carrier;
  - (3) The covered person's physician, or other health care professional; and
  - (4) The Commissioner.
- 2. If the notice provided pursuant to paragraph 1. of this subsection G. was not in writing, within forty-eight (48) hours after the date of providing that notice, the independent external review entity shall:
  - a. Provide written confirmation of the decision to the covered person, the carrier, and the Commissioner; and
  - b. Include the information set forth in Section 8.H.2. of this regulation.
- 3. Carrier's responsibility when the adverse determination is reversed by the independent external review entity.
  - a. Immediately upon the carrier's receipt of the independent external review entity's notice of a decision pursuant to paragraph 1. of this subsection G. reversing its adverse determination:
    - (1) The carrier shall approve the coverage that was the subject of its adverse determination; and
    - (2) The carrier shall provide written notice of the approval to the covered person or the covered person's designated representative.
  - b. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.
- H. An expedited external review may not be requested for retrospective adverse determinations.
- I. A carrier's denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor is not eligible for an expedited external review.

#### **Section 10 Binding Nature of External Review Decisions**

- A. An external review decision is binding on the carrier and the covered person except to the extent the carrier and covered person have other remedies available under federal or state law; however, the determination of the expert reviewer will create a rebuttable presumption in any subsequent action.
- B. A covered person or the covered person's designated representative may not file a subsequent request for external review involving the same carrier's adverse determination for which the covered person has already received an external review decision pursuant to this regulation.



**Section 11      Approval of Independent External Review Entities**

- A. The Commissioner shall approve independent external review entities eligible to be assigned to conduct external reviews under this regulation to ensure that an independent external review entity satisfies the minimum qualifications established under Section 12 of this regulation.
- B. Application shall be made on a form specified by the Commissioner for approving independent external review entities to conduct external reviews.
- C. Any independent external review entity wishing to be approved to conduct external reviews under this regulation shall submit a completed application form, including any documentation or information necessary for the Commissioner to determine if the independent external review entity satisfies the minimum qualifications established under Section 12 of this regulation.
- D. Expiration of approval.
  - 1. An approval is effective for two (2) years, unless the Commissioner determines before expiration of the approval that the independent external review entity is not satisfying the minimum qualifications established under Section 12 of this regulation.
  - 2. Whenever the Commissioner determines that an independent external review entity no longer satisfies the minimum requirements established under Section 12 of this regulation, the Commissioner shall notify the independent external review entity that its approval has been withdrawn and remove the independent external review entity from the list of independent external review entities approved to conduct external reviews under this regulation that is maintained by the Commissioner pursuant to subsection E.
- E. The Commissioner shall maintain and update, as necessary, a list of approved independent external review entities.
- F. The Commissioner may rely on the accreditation status of an applicant independent external review entity as demonstration of fulfillment of any or all requirements of this Section.

**Section 12      Minimum Qualifications for Independent External Review Entities**

- A. To be approved under Section 11 of this regulation to conduct external reviews, an independent external review entity shall meet the requirements of § 10-16-113.5(4), C.R.S., and shall:
  - 1. Agree to maintain and provide to the Commissioner the information set out in Section 14 of this regulation; and
  - 2. Submit to the Commissioner, with the application for approval as an independent external review entity, a schedule of reasonable fees to be charged to carriers for performance of external review, including administrative fees as described in Section 15.
- B. The independent external review entity shall be accredited as an independent review organization by a nationally recognized private accrediting organization.
- C. All expert reviewers assigned by an independent external review entity to conduct external reviews shall be physicians or other appropriate health care providers who meet the minimum qualifications and conflict of interest requirements described in § 10-16-113.5(2)(d), C.R.S.

### **Section 13      External Review Record Requirements**

- A.      An independent external review entity assigned pursuant to Section 8 or 9 of this regulation to conduct an external review shall maintain written records in the aggregate and by carrier on all requests for external review for which it conducted an external review for the Division during a calendar year. The independent external review entity shall retain the written records required pursuant to this subsection for at least three (3) years.
- B.      Each carrier shall maintain written records in the aggregate and for each type (i.e., indemnity, preferred provider organization (PPO), health maintenance organization (HMO), and point-of-service (POS)) of health coverage plan offered by the carrier on all requests for external review that are filed with the carrier. The carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

### **Section 14      Funding of External Review**

The carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost, consistent with the fee schedule the independent external review entity filed with the Commissioner, to the independent external review entity for conducting the external review. In the case of a carrier reversing a denial which is the subject of an external review after assignment of the review to independent external review entity, but prior to assignment of an expert reviewer, the carrier shall pay an administrative fee to the independent external review entity. Charges for the independent external review, when denial is reversed by the carrier prior to review completion but after assignment to an expert reviewer, shall be the full cost.

### **Section 15      Severability**

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

### **Section 16      Enforcement**

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

### **Section 17      Effective Date**

This amended regulation shall become effective on December 1, 2013.

### **Section 18      History**

Originally promulgated with an effective date of April 1, 2000 for the approval process for independent expert review entities and an effective date of June 1, 2000 for the external review process.

Amended effective October 1, 2003 to delete reporting requirements since the Division of Insurance already tracks external review information.

Amended effective October 1, 2004, to clarify the options available after a covered person receives a final adverse determination.

Amended effective February 1, 2006.

Amended effective November 1, 2010.

Amended effective September 1, 2011.

Amended regulation effective December 1, 2013.

**Regulation 4-2-22      INSURER ASSESSMENTS FOR COVERCOLORADO [Repealed eff. 01/01/2014]**

**Regulation 4-2-23      PROCEDURE FOR PROVIDER-CARRIER DISPUTE RESOLUTION**

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

**Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-3-1110, 10-16-109, and 10-16-708, C.R.S.

**Section 2      Scope and Purpose**

The purpose of this regulation is to establish procedures for resolution of provider-carrier disputes, as required by § 10-16-705(13), C.R.S.

**Section 3      Applicability**

The provisions of this regulation shall apply to all carriers when they are providing health care services through managed care plans, except workers' compensation and auto insurance contracts.

**Section 4      Definitions**

A. "Necessary information" consists of the following:

1. Each applicable date of service;
2. Subscriber or member name;
3. Patient name;
4. Subscriber or member number;
5. Provider name;
6. Provider tax identification number;
7. Dollar amount in dispute, if applicable;
8. Provider position statement explaining the nature of the dispute; and
9. Supporting documentation where necessary, e.g., medical records, proof of timely filing.

B. "Participating provider" shall have the same definition as in § 10-16-102(46), C.R.S., and includes any provider that enters into an agreement with a carrier for the provision of a particular health care service or services to a particular insured or insureds.

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- C. "Provider-carrier dispute" means an administrative, payment, or other dispute between a participating provider and a carrier that does not involve a utilization review analysis and does not include routine provider inquiries that the carrier resolves in a timely fashion through existing informal processes.
- D. "Provider-carrier dispute log" means a record of provider dispute resolution requests received by the carrier and maintained on a calendar year basis by the carrier.
1. At a minimum, the log shall include:
    - a. The date of receipt of the dispute resolution request;
    - b. The provider's name and tax identification number;
    - c. The subscriber and patient name;
    - d. The member number;
    - e. The date of service;
    - f. The disputed amount, if applicable;
    - g. The nature of the dispute;
    - h. The date the request was closed;
    - i. Whether the request was pended for additional information; and
    - j. The outcome of the request.
  2. All provider-carrier dispute logs which are produced, obtained by or disclosed to the Commissioner shall be given confidential or privileged treatment to the extent provided by law to protect the privacy of the patient and provider. Confidential or privileged information may not be made public by the Commissioner, except that access to such materials may be granted to the National Association of Insurance Commissioners ("NAIC"). Disclosure of such materials shall be made only upon the prior written agreement of the NAIC to hold such information confidential.
- E. "Provider representative" means a person designated by a provider in writing, including other providers or an association of providers, to represent the provider's interest during the dispute resolution process.
- F. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include, without limitation, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

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**Section 5      Rules**

- A. A carrier shall maintain written procedures for provider-carrier disputes. The procedures shall specify that requests for resolution of provider-carrier disputes must be in writing. All written requests for provider-carrier dispute resolution must be entered into a carrier's provider-carrier dispute log. The log shall be made available to the Commissioner within a reasonable time, upon request.
- B. A carrier shall make a determination of a provider dispute resolution request within forty-five (45) calendar days of receipt of all necessary information. Where the carrier does not receive all necessary information to make a decision, the carrier shall request, in writing, within thirty (30) calendar days of receipt of the provider dispute resolution request, the additional information needed. The carrier shall allow thirty (30) calendar days from the date of the request for any additional information to receive the requested information. If the provider does not respond within the thirty (30) day timeframe, the carrier shall close the request without further review. Further consideration of the closed provider dispute resolution request must begin with a new request by the provider.
- C. Notification requirements.
1. For provider dispute resolution requests where all necessary information was provided, the carrier shall send written confirmation of receipt within thirty (30) calendar days of the dispute resolution request. The written confirmation must contain:
    - a. A description of the carrier's dispute resolution procedures and timeframes;
    - b. The procedures and timeframes for the provider or the provider's representative to present his rationale for the dispute resolution request; and
    - c. The date by which the carrier must resolve the dispute resolution request.

In the instance where the provider dispute resolution request is resolved in accordance with the requirements of this regulation within thirty (30) calendar days, the notice required by Section 5.E. shall constitute the notice required by this Section 5.C.
  2. In cases where the carrier does not receive all necessary information to make a decision, the carrier shall send, within thirty (30) calendar days of receipt of the provider dispute resolution request, a written notice to the provider that must contain:
    - a. A description of the additional necessary information required to process the request;
    - b. The date that additional information must be provided by the provider; and
    - c. A statement that failure to provide the requested information within thirty (30) calendar days from the carrier's request for additional information will result in the closure of the request with no further review.
  3. In cases where the provider does not submit the additional necessary information required by the carrier and the carrier closes the request, the carrier shall notify the provider that the case is closed and that further consideration of the closed dispute resolution request must begin with a new request by the provider.

- D. A carrier shall offer the provider the opportunity to designate a provider representative in the dispute resolution process. The carrier shall allow the provider or the provider's representative the opportunity to present the rationale for the dispute resolution request in person. In cases where the provider determines that a face-to-face meeting is not practical, the carrier shall offer the provider the opportunity to utilize alternative methods such as teleconference or videoconference to present the rationale for the dispute resolution request. The carrier may require appropriate confidentiality agreements from representatives as a condition to participating in the dispute resolution process. The parties may mutually agree in writing to extend the timeframes beyond the forty-five (45) calendar days from receipt of all necessary information timeframe established by this regulation.
- E. A carrier shall provide notification of the determination to the provider. In the event the determination is not in favor of the provider, the written notification shall include the principal reasons for the determination. The written notification shall contain:
1. The names and titles of the parties evaluating the provider-carrier dispute resolution request, and where the decision was based on a review of medical documentation, the qualifying credentials of the parties evaluating the provider-carrier dispute resolution request;
  2. A statement of the reviewers' understanding of the reason for the provider's dispute;
  3. The reviewers' decision in clear terms and the rationale for the carrier's decision; and
  4. A reference to the evidence or documentation used as the basis for the decision.
- F. All requirements in this regulation concerning written notification may be met by electronic means, including e-mail or facsimile, as long as confirmation of the transmission can be shown.
- G. Nothing in this regulation shall be construed to supersede contract provisions that do not directly conflict with the terms of this regulation. For example, after a final determination is made by the carrier in accordance with the requirements set forth in this regulation, any further consideration of the request shall be handled in accordance with the contract provisions between the carrier and the provider, i.e., the request may be subject to mandatory arbitration as stated in the contract.

## **Section 6 Severability**

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

## **Section 7 Enforcement**

Noncompliance with this regulation may result in the imposition of any sanctions made available in Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process. Among others, the penalties provided for in § § 10-3-1108 and 10-3-1110(2), C.R.S., may be applied. Failure of a carrier to employ the procedures outlined in this regulation constitutes an unfair or deceptive act in the business of insurance under § 10-3-1104(1)(h)(IV), C.R.S.

## **Section 8 Effective Date**

This regulation is effective on December 15, 2013.

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**Section 9 History**

New regulation, effective August 1, 2002.  
Amended regulation effective September 1, 2011.  
Amended regulation effective January 1, 2012.  
Amended regulation effective December 15, 2013.

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

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Additional Information
Section 7	Severability
Section 8	Incorporated Materials
Section 9	Enforcement
Section 10	Effective Date
Section 11	History

**Section 1 Authority**

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

**Section 2 Scope and Purpose**

This regulation outlines the requirements to determine whether or not a claim will be considered a clean claim, as well as the requirements for carriers processing each as required for a prompt payment of claims.

**Section 3 Applicability**

This regulation applies to any entity that provides health coverage in this state including a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to Article 16 of the insurance laws of Colorado. This regulation also applies to those long-term care companies that submit claims on the CMS 1450 and CMS 1500 claim forms.

**Section 4 Definitions**

- A. "Additional information" means, for the purposes of this regulation, information beyond what was submitted with the initial claim that is required to enable a carrier to determine its liability and resolve a claim.
- B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- C. "Clean claim" means, for the purposes of this regulation, a claim for payment of health care expenses with all essential fields completed with correct and complete information required by the carrier to determine its liability.

- D. "Essential field" means, for the purposes of this regulation, a field on a claim form, whether electronic or in any other form, that is not only required according to standards set forth by The Health Insurance Portability and Accountability Act (HIPAA), but is also necessary for the carrier to determine its liability and resolve the claim.
- E. "Pended claim" means, for the purposes of this regulation, a claim which is held in an open or suspended status until requested additional information needed to resolve the claim is received or for at least thirty (30) days after a request for additional information is sent, whichever occurs first.
- F. "Supplemental field" means, for the purposes of this regulation, a field on a claim form, whether electronic or in any other form, that is required or necessary only when it clarifies or quantifies the information in an essential field of a claim.
- G. "Timely submit" means, for the purposes of this regulation, to provide to a carrier information or documentation requested within the time period required by § 10-16-106.5(4)(b), C.R.S.
- H. "Unclean claim" means, for the purposes of this regulation, a claim for which information in the essential fields is missing, incorrect or incomplete, and additional information is needed by a carrier to determine its liability to resolve the claim.

## **Section 5      Rules**

- A. Clean claims shall be submitted in the appropriate format (electronic or paper) as required, must utilize the appropriate form (the American Dental Association Dental Claim Form, the CMS 1500 Form, or the CMS 1450 (UB-04) Form) or electronic equivalent, and shall include all essential fields necessary for the carrier to determine its liability and resolve the claim. In the case of a dispute over the status of a claim as clean or unclean, the Division shall make the final determination as to what fields are essential.
- B. When all of the information or documentation necessary to resolve a claim is initially provided in the appropriate claim form or format that includes all of the essential fields and any supplementary fields needed for that claim, the claim shall be considered a clean claim and processed within the timeframes specified in § 10-16-106.5(4), C.R.S.
- C. A carrier shall send a request for additional information necessary to resolve an unclean claim within thirty (30) calendar days after receipt of the claim pursuant to §10-16-106.5(4)(b), C.R.S.
- D. A carrier shall pend an unclean claim, as defined in Section 4.H. of this regulation, and hold such claim in an open or suspended status until requested additional information needed to resolve the claim is received or for at least thirty (30) days after a request for additional information is sent, whichever occurs first.
- E. A carrier shall not deny an unclean claim, as defined in Section 4.H. of this regulation, for lack of required or incorrect information without requesting the information needed to determine its liability and without allowing the required time period for the additional information to be submitted.
- F. A claim shall not be considered unclean if the information provided in the required format is missing or incorrect unless that information is an essential field or is required by the carrier to determine its liability and resolve the claim.
- G. A carrier shall pay interest as appropriate pursuant to § 10-16-106.5(5), C.R.S., when clean claims are not paid, denied, or settled within the specified time periods.



- H. A carrier shall pay interest pursuant to § 10-16-106.5(5), C.R.S., when additional information necessary for resolving an unclear claim is not requested within the required time period or when the carrier denies an unclear claim without holding the claim in a pended status for at least thirty (30) days or until the information is received, following a request for additional information.
- I. A carrier shall pay a penalty equal to twenty percent (20%) of the total amount ultimately allowed on all claims not paid, denied or settled within ninety (90) days after receipt of the claim.

**Section 6 Additional Information**

- A. A claim with all required fields completed is not considered “clean” if additional information is needed in order to resolve the claim. Carriers may request additional information only if the carrier’s claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made.
- B. When additional information is required, the carrier shall make the specific request in writing within thirty (30) calendar days after receipt of the claim. If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. The specific information required shall be requested within thirty (30) calendar days after receipt of the claim form and identified for the provider upon request.
- C. Additional information requested must be related to information in the essential fields of the claim. This applies even though the genesis of the request may be from other sources, e.g., if the carrier has other information that indicates the information in an essential field is incorrect, such as previous claims that indicate the treatment was for work-related injuries when the claim submitted indicates otherwise. Requests for additional information to determine if the treatment is medically necessary would be related to the fields specifying the services provided.
- D. A carrier is not permitted to request additional information for the purpose of determining medical necessity when the claim form has all essential and supplementary fields correctly completed and the services were preauthorized pursuant to § 10-16-704(4), C.R.S.
- E. The following circumstances are those for which additional information is generally required by most health carriers:
  - 1. When the coverage is not primary, an explanation of benefits form from the primary payer;
  - 2. When service/procedure codes indicate “unusual” procedural services or anesthesia, the medical records to justify medical necessity;
  - 3. When surgical procedures utilize multiple surgeons or surgical assistants, the medical records to justify medical necessity;
  - 4. When the procedure is a repeat procedure, the medical records to justify medical necessity;
  - 5. When supplies and materials are ordered on an outpatient basis, the medical records and/or invoice to justify medical necessity or allowable fee; and
  - 6. When services are billed using a “by report” or unlisted CPT code, the medical records to substantiate the claim.

- F. If a managed care plan requires medical or other records on all claims for particular types of services/procedures or diagnosis codes, the carrier must clearly disclose such requirements in the provider contract, provider manual, or provider manual updates. If a carrier contracts with an intermediary, the carrier shall be responsible for making sure the intermediary provides such disclosure to contracted providers in a timely manner.
- G. When requesting medical records, carriers must identify the particular component(s) of the medical record being requested or indicate the specific reason for the request, e.g., progress reports for most recent three months, or records to establish the medical necessity of the treatment provided. The records requested must be related to the service/procedure of the claim and limited to the minimum amount of information necessary. Requests for “all medical records” are not specific enough and would not be an acceptable request for claim adjudication.
- H. Medical information requested from institutional providers shall be limited to the following:
  - 1. History and physical reports;
  - 2. Consultant reports;
  - 3. Operative reports;
  - 4. Discharge summaries;
  - 5. Emergency department reports;
  - 6. Diagnostic reports; and
  - 7. Progress reports.

## **Section 7 Severability**

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

## **Section 8 Incorporated Materials**

The Centers for Medicare and Medicaid Services “CMS 1500 Form”, published by the National Uniform Claim Committee shall mean “CMS 1500 Form” as published on the effective date of this regulation and does not include later amendments to or editions of the “CMS 1500 Form.” The Centers for Medicare and Medicaid Services “CMS 1500 Form” may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Centers for Medicare and Medicaid Services Website at [http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16\\_1500.html](http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html). Certified copies of The Centers for Medicare and Medicaid Services “CMS 1500 Form” are available from the Colorado Division of Insurance for a fee.

The Centers for Medicare and Medicaid Services “CMS 1450 (UB-04) Form”, published by the National Uniform Billing Committee shall mean “CMS 1450 Form” as published on the effective date of this regulation and does not include later amendments to or editions of the “CMS 1450 Form.” The Centers for Medicare and Medicaid Services “CMS 1450 Form” may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Centers for Medicare and Medicaid Services Website at [http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15\\_1450.html](http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450.html). Certified copies of Tthe Centers for Medicare and Medicaid Services “CMS 1450 Form” are available from the Colorado Division of Insurance for a fee.

The American Dental Association “ADA Dental Claim Form,” published by the American Dental Association shall mean “ADA Dental Claim Form” as published on the effective date of this regulation and does not include later amendments to or editions of the “ADA Dental Claim Form.” The American Dental Association “ADA Dental Claim Form,” may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting The American Dental Association Website at <http://www.ada.org/7119.aspx>. Certified copies of the American Dental Association “ADA Dental Claim Form” are available from the Colorado Division of Insurance for a fee.

## **Section 9      Enforcement**

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

## **Section 10      Effective Date**

This regulation is effective January 1, 2014.

## **Section 11      History**

Emergency Regulation 02-E-7, effective July 2, 2002.  
Temporary Regulation 02-T-7, effective October 1, 2002.  
Regulation 4-2-24 effective February 1, 2003.  
Amended Regulation 4-2-24 effective February 1, 2008.  
Amended Regulation effective June 1, 2012.  
Amended Regulation effective January 1, 2014.

**Regulation 4-2-25      Repealed in Full [Eff. 04/01/2009]**

**Regulation 4-2-26      Repealed in Full [Eff. 11/01/2010]**

## **Regulation 4-2-27      PROCEDURES FOR REASONABLE MODIFICATIONS TO INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Notice and Disclosure of Reasonable Modifications
Section 7	Severability
Section 8	Enforcement
Section 9	Effective Date
Section 10	History

## **Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-16-109, 10 16 105.1(6), C.R.S. and § 10-16-201.5(8)(b), C.R.S.(2012).

## **Section 2      Scope and Purpose**

The purpose of this regulation is to establish procedures for the submission of reasonable modifications to grandfathered individual and small group health benefit plans, as outlined in § 10-16-201.5(8), C.R.S. (2012), and for individual and small group non-grandfathered health benefit plans, as outlined in § 10-16-105.1(5), C.R.S.

## **Section 3      Applicability**

This regulation applies to any carrier intending on making reasonable modifications to an individual or small group health benefit plan.

## **Section 4      Definitions**

- A. "Reasonable modification" means, for the purpose of this regulation, an alteration to the benefits of a health benefit plan that is fair and reasonable under the circumstances. The Division of Insurance (Division) determines if a modification is fair and reasonable.
- B. "PPACA" or "ACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

## **Section 5      Rules**

- A. Requirements for Reasonable Modifications
  - 1. Timing and Submission: The proposed benefit modification change request must be submitted via SERFF in the form of a letter to the Commissioner and policyholders at least ninety (90) days prior to the effective date of the modification.
  - 2. The Rates and Forms Section of the Division will no longer accept reasonable modifications submitted by paper. Only SERFF filings will be accepted unless there is a compelling reason that such a reasonable modification can only be filed in a paper format.
  - 3. Carrier Specific: A separate filing must be submitted for each carrier. A single filing, which is made for more than one carrier or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan.
  - 4. Required Information: A cover letter, side-by-side comparison of the benefit change(s), an identification of the rating impact of each benefit change and a copy of the policyholder notification.
    - a. Side-by-Side Comparison: Each filing must include a "side-by-side comparison" identifying the proposed change(s). The "side-by-side comparison" should include three columns:
      - (1) The first column containing a description of the current benefit, including form number, if applicable;
      - (2) The second column containing the proposed benefit change(s); and
      - (3) The third column containing the amount of the rating impact for each of the proposed change(s).

All changes to the rates must be filed separately in accordance with all rating laws and regulations once the Division and the carrier have resolved all issues.

- b. All carriers shall submit a cover letter to the Commissioner which contains the following:
  - (1) A complete explanation of what the carrier is proposing to do;
  - (2) The effective date of the proposed modification;
  - (3) The market type of the plan being modified (i.e., individual, small group, or both);
  - (4) Whether the plan is a grandfathered plan or a non-grandfathered plan;
  - (5) The form numbers and plan identification code, as appropriate, for the forms and plans to be modified; and
  - (6) The number of groups and members affected by the modification.
- c. If the modification is determined by the Division to be reasonable, and all outstanding issues have been resolved, the filing will be approved via SERFF. All rates under the approved modification must be filed separately in SERFF in accordance with all existing rating laws and regulations. If the modification is determined to be unreasonable, it will be disapproved via SERFF.
- d. Rate Filing: Submit a separate rate filing that shall discuss or provide the following:
  - (1) The impact on rates for each of the requested modifications as well as and the overall impact on rates for the entire product;
  - (2) A narrative stating how each of the rating changes was determined; and
  - (3) A signed certification that the methodology used to determine the rates for these benefit modifications is consistent with the methodology used by the carrier to price similar products.
- e. Rate filings require a separate forms filing that contains the following pursuant to § 10-16-107.2, C.R.S., Colorado Insurance Bulletin B-4.18, and with Colorado Insurance Regulation 4-2-39, and must include:
  - (1) The signed forms certification; and
  - (2) The new forms listing to include the effective date of the modified form.

**B. Losing Grandfathered Status**

- 1. Removal of an existing benefit is generally not considered to be a reasonable modification. However, the Division may determine, on a case-by-case basis, if the removal of an existing benefit is reasonable after reviewing the supporting documentation. If the removal is not found to be a reasonable modification, the associated plan would lose its grandfathered status.

2. Making a change to a grandfathered plan that would cause a grandfathered plan to lose its grandfathered status includes, but is not limited to:
  - a. Adding or changing of an overall annual dollar limit on all benefits by adding a limit to a plan that, on March 23, 2010, did not have an overall lifetime or annual dollar limit on all benefits;
  - b. Reducing the dollar amount of the annual limit; or
  - c. Reducing the overall lifetime dollar limit on all benefits that was in place on March 23, 2010.
3. A change to a grandfathered plan that changes the cost sharing and/or the actuarial value of an existing policy is not considered a reasonable modification.
4. Any modification to a grandfathered, non-ACA compliant, plan in order to bring it into compliance with the requirements of the ACA and create an ACA-compliant product will not be considered a "reasonable modification."

#### **Section 6 Notice and Disclosure of Reasonable Modifications**

The policyholder notification shall be provided no later than ninety (90) days prior to renewal of each policyholder's benefit plan. It shall provide the policyholder an opportunity to purchase any other health benefit plan offered by the carrier in that specific market. A copy of this notification must be provided to the Division as part of the benefit modification filing. A reasonable modification does not qualify as an event that results in a special enrollment period.

#### **Section 7 Severability**

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

#### **Section 8 Enforcement**

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

#### **Section 9 Effective Date**

This regulation shall become effective on January 1, 2014.

#### **Section 10 History**

Regulation effective January 1, 2005.  
Amended regulation effective May 1, 2010.  
Amended regulation effective January 1, 2014.

#### **Regulation 4-2-28 CONCERNING THE PAYMENT OF EARLY INTERVENTION SERVICES FOR CHILDREN ELIGIBLE FOR BENEFITS UNDER PART C OF THE FEDERAL "INDIVIDUALS WITH DISABILITIES EDUCATION ACT"**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability

Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Incorporated Materials
Section 9	Effective Date
Section 10	History

## **Section 1 Authority**

This regulation is being promulgated and adopted by the Commissioner of Insurance under the authority of § 10-1-109, 10-16-104(1.3) and 27-10.5-709(2), C.R.S.

## **Section 2 Scope and Purpose**

The purpose of this regulation is to provide health carriers the guidance necessary to facilitate the payment of early intervention services by private insurance sources and to incorporate the changes made to those payments by House Bill 13-1266. This regulation replaces emergency regulation 13-E-12 in its entirety.

## **Section 3 Applicability**

This regulation applies to all individual and group sickness and accident insurance policies and all service or indemnity contracts issued or renewed on or after January 15, 2014, by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes, which provide coverage for health care services.

## **Section 4 Definitions**

- A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- B. "Case management services" means, for the purposes of this regulation, the service coordination activities as defined in 34 CFR 303.34.
- C. "Certified early intervention service broker" or "broker" means, for the purposes of this regulation, a community centered board or other entity designated by the Colorado Department of Human Services to perform the specified duties and functions in a particular designated service area and may include the Division of Community and Family Support acting as the broker for any service area until another broker has been designated.
- D. "Division of Community and Family Support" means, for the purposes of this regulation, a division of the Colorado Department of Human Services.
- E. "Early intervention services" shall have the same meaning as found at § 10-16-104(1.3)(a)(II), C.R.S., and include monthly case management service costs and fees.
- F. "Eligible child" shall have the same meaning as found at § 10-16-104(1.3)(a)(III), C.R.S.
- G. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.
- H. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- I. "Individualized family service plan" or "IFSP" shall have the same meaning as found at § 10-16-104(1.3)(a)(IV), C.R.S.

- J. "Limited benefit health insurance" means, for the purposes of this regulation, a health policy, contract or certificate offered or marketed on an individual or group basis as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments or coinsurance amounts not covered by a health benefit plan. "Limited benefit health insurance" does not include short-term limited duration health insurance policies, contracts or certificates; high deductible plans; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan".
- K. "Registry" means, for the purposes of this regulation, a listing of early intervention service providers established by the designated area's certified early intervention service broker. The broker may provide early intervention services directly or may subcontract the provision of services to other qualified providers in the registry.
- L. "Qualified early intervention service provider" or "qualified provider" shall have the same meaning as found at § 10-16-104(1.3)(a)(VI), C.R.S.

**Section 5      Rules**

- A. Eligible early intervention services specified in the eligible child's IFSP shall meet the carrier's test of medically necessary services. Therefore, carriers shall arrange for the payment of claims for early intervention services provided to an eligible child received from qualified early intervention service providers listed in the registry.
- B. The certified early intervention service broker will notify the carrier within ten (10) days of determining that a child, up to age three (3), is eligible for early intervention services. This notification will include, at a minimum:
1. The eligible child's name;
  2. The eligible child's date of birth;
  3. The policy number; and
  4. The name of the primary insured or policyholder.
- C. Trust Payments.
1. Upon the receipt of a new IFSP for an eligible child, carriers shall pay an amount equal to the annual monetary benefit, as established in Section 5.E. of this regulation, into the trust established by the Colorado Department of Human Services (CDHS) as provided in § 27-10.5-709(1), C.R.S., within thirty (30) days of receipt of an invoice issued by CDHS.
  2. For an eligible child covered by a plan subject to the requirements of sections 5.E.1 or 5.E.2:
    - a. If funds remain in the trust after the required benefits and associated case management costs and fees, the trust will refund the balance to the carrier when it performs its reconciliation for the eligible child.
    - b. If the funds deposited are not enough to cover the services billed for the required number of visits and associated case management costs and fees, the carrier will deposit an additional amount in increments of \$1,000, as needed, until all required services and fees have been paid. Remaining funds will be refunded in accordance with section 5.C.2.a.



- D. Eligible early intervention services do not include:
1. Non-emergency medical transportation;
  2. Respite care;
  3. Service coordination other than case management services; or
  4. Assistive technology. However, assistive technology may be covered by the policy's durable medical equipment benefit provisions.
- E. Benefit and payment requirements.
1. For non-grandfathered plans issued or renewed on or after January 15, 2014, coverage must be provided for no less than forty-five (45) visits annually for early intervention services and associated case management costs and fees, with no dollar limit imposed upon those visits.
  2. As of January 1, 2013, for grandfathered health benefit plans, the maximum annual monetary benefit payable for all eligible early intervention and case management costs and fees, is \$6,361.00. Thereafter, on January 1 of each year, the maximum annual benefit payable shall be adjusted based on the consumer price index for the Denver-Boulder-Greeley metropolitan statistical area for the state fiscal year that ends in the preceding calendar year or by such additional amount to be equal to the increase by the General Assembly to the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that increase is more than the consumer price index increase. The new maximum annual benefit amount will be published in a bulletin by the Colorado Division of Insurance.
  3. Any covered benefit payable for the following services shall not be subject to the annual benefit amounts specified in paragraphs 1. and 2. of this subsection E.:
    - a. Rehabilitation or therapeutic services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
    - b. Services provided to a child who is not participating in Part C of the Federal "Individuals with Disabilities Education Act" and services that are not provided pursuant to an IFSP; and
    - c. Assistive technology that is covered by the policy's durable medical equipment benefit provisions.
  4. Qualified early intervention service providers that receive reimbursement in accordance with paragraphs 1. and 2. of this subsection DE. shall accept such reimbursement as payment in full for services provided under § 10-16-104(1.3), C.R.S., and shall not seek additional reimbursement from either the covered person or the carrier.
- F. The Division of Community and Family Support will notify the carrier within ninety (90) days if a child is no longer eligible for early intervention services.
- G. Short-term, accident, fixed indemnity, specified disease policies, disability income contracts, limited benefit health insurance plans, credit disability insurance and Medicare supplement policies are not required to provided the benefits set forth in § 10-16-104(1.3), C.R.S.

- H. The carrier shall return requests for verification of eligibility of coverage of the eligible child to the certified early intervention service broker within five (5) business days of receipt.

#### **Section 6 Severability**

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

#### **Section 7 Enforcement**

Noncompliance with this regulation may result 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 Incorporated Materials**

Section 303.34 of Title 34 (Early Intervention Program for Infants and Toddlers with Disabilities), Code of Federal Regulations published by the Government Printing Office shall mean Section 303.34 of Title 34 as published on the effective date of this regulation and does not include later amendments to or editions of Section 303.34 of Title 34. A copy of Section 303.34 of Title 34 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of Section 303.34 of Title 34 may be requested from the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at [www.ecfr.gov](http://www.ecfr.gov).

#### **Section 9 Effective Date**

This regulation shall become effective on January 15, 2014.

#### **Section 10 History**

Emergency regulation 07-E-3 is effective December 3, 2007.

New regulation effective March 1, 2008.

Emergency regulation 09-E-01 is effective June 15, 2009.

Amended regulation effective October 1, 2009.

Amended regulation effective January 15, 2014.

### **Regulation 4-2-29 CONCERNING THE RULES FOR STANDARDIZED CARDS ISSUED TO PERSONS COVERED BY HEALTH BENEFIT PLANS**

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

#### **Section 1 Authority**

This regulation is being promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, and 10-16-135, C.R.S.

## **Section 2      Scope and Purpose**

The purpose of this regulation is to provide health carriers the guidance necessary to comply with the statutory requirements regarding the issuance and use of a health benefit plan identification cards, pursuant to § 10-16-135, C.R.S.

## **Section 3      Applicability**

This regulation applies to all individual and group health benefit plans issued or renewed on or after July 1, 2009 by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes, and to any person enrolling in an existing plan on or after July 1, 2009.

## **Section 4      Definitions**

- A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- B. "Clear and conspicuous" means, for the purpose of this regulation, the placement of the required information will be set apart from other information listed to allow it to be easily located on the card.
- C. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- D. "Limited benefit health insurance" means, for the purpose of this regulation, a health policy, contract or certificate offered or marketed on an individual or group basis as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments or coinsurance amounts not covered by a health benefit plan. "Limited benefit health insurance" does not include short-term limited duration health insurance policies, contracts or certificates; high deductible plans; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan".
- E. "Short-term limited duration health insurance policy" shall have the same meaning as found at § 10-16-102(60).

## **Section 5      Rules**

- A. The requirements of this regulation shall apply to identification cards issued to persons covered under health benefit plans. These requirements do not apply to identification cards issued to persons covered by limited benefit health insurance plans.
- B. The card size shall be approximately 2.125 inches by 3.370 inches, which is consistent with standard-sized credit cards, and shall be either be made of plastic or be laminated. Cards issued in connection with coverage provided by short-term limited duration health insurance policies do not have to be made of plastic or be laminated.
- C. The colors used for the card and font shall be legible and conducive to black and white photocopying.
- D. The following information shall appear on the front side of the identification card, in no less than 8 point font:
  - 1. The legal name of the carrier underwriting the policy, but a "dba" may also be included;
  - 2. The covered person's first name, middle initial (if applicable), and last name;

3. Any applicable policy, certificate, or group numbers, and the subscriber's or covered person's identifying number, as applicable, which is sufficient to identify the covered person with the policy;
  4. The specific plan number or name;
  5. The plan type (such as HMO (Health Maintenance Organization), POS (Point-of-Service), PPO (Preferred Provider Organization), or Indemnity (non-managed care plan));
  6. Coverage levels for the following services. If all services are subject to the plan's deductible and applicable coinsurance, a non-specific amount notation of "Deductible and coinsurance" is sufficient; otherwise, the required copayments shall be specified. If both a deductible and copayment apply, a non-specific amount notation of "Deductible" is sufficient, followed by the specified copayment amount.
    - a. Primary care;
    - b. Specialty care;
    - c. After hours/urgent care;
    - d. Emergency room; and
    - e. Inpatient hospital.
  7. The designation "CO-DOI" for any and all plans regulated in whole or in part by the State of Colorado's Division of Insurance. This designation shall be placed on the card in a clear and conspicuous manner.
- E. The following information shall appear on either the front or reverse side of the identification card at the carrier's discretion, in no less than 8 point font:
1. Contact information for the carrier or plan administrator which includes:
    - a. Name and address for claim submissions;
    - b. Telephone number(s) for member/customer service;
    - c. Website address;
    - d. If applicable, a statement that preauthorization or notification for hospitalization or other services may be required and the telephone number to obtain such preauthorization or to make such notification.
    - e. If the carrier does not use its own managed care provider network, the logo, name of the network, website, or toll-free number where provider network information can be readily obtained.
  2. "Card issued" date; however, this date shall be displayed in a clear and conspicuous manner.
- F. The card may include other information at the carrier's discretion.

- G. Carriers may utilize commonly-known abbreviations or acronyms for the purposes of displaying the information required by paragraph 6. of subsection D., such as:
1. "PCP" to describe or refer to primary care physician benefits;
  2. "SCP" to describe or refer to specialty care physician benefits;
  3. "Urgent" to describe or refer to after hours/urgent care benefits;
  4. "ER" to describe or refer to "emergency room" benefits;
  5. "Hospital" to describe or refer to inpatient hospital benefits;
  6. "Ded" or "deduct" to describe the application of the policy's deductible; or,
  7. "Co-ins" to describe the application of the policy's coinsurance requirements.
- H. Carriers choosing to utilize commonly known abbreviations or acronyms in accordance with subsection G. shall provide an explanation of the abbreviations and/or acronyms displayed on the card in the information provided when the card is sent to the covered person.

#### **Section 6 Severability**

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

#### **Section 7 Enforcement**

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

#### **Section 8 Effective Date**

This regulation shall become effective on December 15, 2013.

#### **Section 9 History**

New regulation effective October 1, 2008.  
Amended regulation, effective July 1, 2009.  
Amended regulation, effective December 15, 2013.

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

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

**Section 1      Authority**

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

**Section 2      Scope and Purpose**

The purpose of this regulation is to provide health carriers the guidance necessary to comply with the requirement to provide coverage for prosthetics and hearing aids pursuant to § 10-16-104(14) and (19), C.R.S., respectively.

**Section 3      Applicability**

This regulation applies to all individual and group health benefit plans issued or renewed by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes.

**Section 4      Definitions**

- A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- B. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- C. "Hearing aid" shall have the same meaning as found at § 10-16-102(38), C.R.S.
- D. "Limited benefit health insurance" means, for the purpose of this regulation, a health policy, contract or certificate offered or marketed on an individual or group basis as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments or coinsurance amounts not covered by a health benefit plan. "Limited benefit health insurance" does not include short-term limited duration health insurance policies, contracts or certificates; high deductible plans; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan".
- E. "Minor child" shall have the same meaning as found at § 10-16-102(44), C.R.S.

**Section 5      Rules**

- A. Hearing aids.
  - 1. For the purposes of § 10-16-104(19), C.R.S., hearing aids do not meet the traditional definition of durable medical equipment; therefore, any benefits paid for a minor child's hearing aid(s) in accordance with the coverage mandated by Colorado law shall not be used to exhaust a health benefit plan's annual durable medical equipment maximum, if any.
  - 2. The mandated coverage of hearing aids for a minor child shall be provided subject to the same annual deductible and/or copayment/coinsurance levels established for other covered benefits. Benefits shall be determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in § 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

3. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. This requirement shall apply to each hearing aid if the minor child has two hearing aids.
- B. For the purposes of §10-16-104(14), C.R.S., prosthetics do not meet the traditional definition of durable medical equipment; therefore, any benefits paid for prosthetics in accordance with the coverage mandated by Colorado law shall not be used to exhaust a health benefit plan's annual durable medical equipment maximum, if any.

## **Section 6 Severability**

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

## **Section 7 Enforcement**

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

## **Section 8 Effective Date**

This regulation shall become effective on December 15, 2013.

## **Section 9 History**

Emergency Regulation 08-E-11 effective January 1, 2009.

New regulation 4-2-30 effective February 1, 2009.

Amended regulation, effective December 15, 2013.

## **Regulation 4-2-31 ANNUAL HEALTH REPORTING AND DATA RETENTION REQUIREMENTS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Hospital Reimbursement Rate Record Retention and Report
Section 6	Annual Cost Report
Section 7	Annual Excess Loss Report
Section 8	Incorporated Materials
Section 9	Severability
Section 10	Enforcement
Section 11	Effective Date
Section 12	History

## **Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-109, 10-16-111(4), 10-16-119(3) and 10-16-134, C.R.S.

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## **Section 2      Scope and Purpose**

The purpose of this regulation is to define uniform reporting, filing and data retention requirements for the hospital reimbursement rate report and the Annual Cost Report.

## **Section 3      Applicability**

This regulation applies to all carriers, as defined in Section 4.B. of this regulation, operating in the state of Colorado with written health premium in the data year. This includes, but is not limited to carriers operating with the following types of business: comprehensive health insurance, Health Maintenance Organization (HMO) coverage, supplemental health, limited service licensed provider network business, long-term care, disability income, accident-only, specified or dread disease, hospital indemnity, vision only, dental only, other limited-medical payment plans, Medicare supplement and excess loss insurance (pursuant to §§ 10-16-119 and 10-16-119.5, C.R.S.).

Reporting of information is waived as shown for each report:

### **A.      Hospital Reimbursement Rate Report**

The following types of business are waived: Limited medical-payment plans (including disability income, accident only, specified or dread disease, hospital indemnity, vision only, and dental only), Medicare, Medicaid, long term care, and Medicare supplement insurance.

### **B.      Annual Cost Report**

The Division has been granted authority to waive the reporting requirement for carriers responding to the Colorado Health Cost Report so long as at least those representing the top ninety-two percent (92%) of earned premium market share respond. Companies required to respond will be contacted through email sent to the Market Conduct Contact on file with the National Association of Insurance Commissioners (NAIC).

The calculation determining which carriers are waived from being required to report will utilize Colorado-specific data in exhibits from the most recently-filed NAIC Annual Statement for carriers required to report to the NAIC at the time of each Annual Cost Report. Specific information on the annual waiver methodology can be found in Colorado Insurance Bulletin No. B-4.58.

### **C.      Annual Excess Loss Report**

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

## **Section 4      Definitions**

- A.**      “Average reimbursement rate” means, for the purposes of this regulation, is the average of all reimbursement rates that a carrier paid, by MS-DRG code, to only hospitals/facilities reporting to the Colorado Hospital Association during the previous calendar year including both in-network and out-of-network facilities.
- B.**      “Carrier”, for the purposes of this regulation, shall have the same meaning as found at § 10-16-102(8), C.R.S.



- C. "Diagnostic-Related Group" and "Diagnosis-Related Group" means, for purposes of this regulation, the classification assigned to an inpatient hospital service claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed, and the discharge status.
- D. "Dividends" means, for purposes of this regulation, both policyholder and stockholder dividends.
- E. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.
- F. MS-DRG" (Medicare Severity Diagnosis Related Group) is a code within a system developed for Medicare as part of its payment system to classify each hospital case into one of approximately 500 groups that is published by the Centers for Medicare and Medicaid Services in the FY 2014 Final Rule Tables, Table 5.
- G. "Premium" means, for purposes of this regulation, the amount of money paid on behalf of the insured as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier's expectation of the insured's future claim costs and the insured's share of the carrier's claims settlement, operational and administrative expenses, and the carrier's cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.
- H. "Reimbursement rate" means, for the purposes of this regulation, the amount, by MS-DRG code, that a carrier paid for a procedure at a facility or hospital, plus any expected deductible, copayment, and/or coinsurance. It is important that only the entire hospital/facility reimbursement be included in this rate, not just the carrier's portion. Provider reimbursement charges should be excluded from this total. Private room, personal item and other charges that are generally the responsibility of the policyholder should also be excluded.
- I. "Trend," means, for the purposes of this regulation, the rate of increase in costs for the reporting period.
- J. "Excess loss" means, for the purposes of this regulation, individual or group policies providing coverage to a carrier, a self-insured employer plan, or a medical provider providing coverage to insure against the risk that any one claim or an entire plan's losses will exceed a specified dollar amount.

## **Section 5 Hospital Reimbursement Rate Record Retention and Report**

- A. The Division will annually publish on its website or communicate directly to carriers the list of MS-DRG codes associated with the twenty-five (25) most common inpatient procedures performed in Colorado for the previous reporting year. This will include more than twenty-five (25) MS-DRG codes, as there are multiple codes for different levels of severity in many of the identified procedures.
- B. Pursuant to the Health Care Transparency Act, § 10-16-134, C.R.S., each carrier shall report to the Division the average reimbursement rates and number of procedures on a statewide basis for the twenty-five (25) most common inpatient procedures performed in Colorado at hospitals/facilities reporting to the Colorado Hospital Association. This information shall be filed electronically using the Division of Insurance website in a format made available by the Division.
- C. Timing and Submission: The required data shall be filed on or before March 1 of each year. Pursuant to § 10-3-109(2)(a), C.R.S., failure to file this report by March 1 may result in a late penalty not to exceed \$100 per day and any applicable surcharges. Reports not containing all of the information specified in this section may be subject to the assessment of a penalty for an incomplete report.

- D. Each entity subject to the Health Care Transparency Act shall:
1. Maintain its books, records, and documents in a manner that ensures the necessary data can be readily ascertained and reported to the Division.
  2. Format records for each Diagnostic-Related Group to be recorded and classified using the MS-DRG coding format and procedures at the time of discharge.
  3. Ensure that reimbursement/claim records shall:
    - a. Be maintained to clearly identify the MS-DRG code assigned and reimbursement rate of each procedure;
    - b. Be sufficiently clear and specific so that the pertinent dates, locations, cases and charges of these events can be reconstructed; and
    - c. Include and, if necessary, calculate the complete reimbursement rate, hospital/facility, and MS-DRG Code for each inpatient procedure.

**Section 6      Annual Cost Report**

- A. Pursuant to § 10-16-111(4)(a), C.R.S., carriers subject to this regulation shall file an Annual Cost Report as described in this section. This report must comply with the requirements of this section and must contain the information specified in subsection C. of this section and shall be filed electronically via a form provided on the Division of Insurance website, [www.dora.colorado.gov/insurance](http://www.dora.colorado.gov/insurance).
- B. Timing and Submission: All Annual Cost Reports shall be filed electronically in a format made available by the Division of Insurance via the Division's website on or before June 1 of each year. Pursuant to § 10-3-109(2)(a), C.R.S., failure to file this report by June 1 will result in a late penalty not to exceed \$100 per day. Reports not containing complete and accurate information specified in subsection C. of this section may be subject to the assessment of a penalty for an incomplete report.
- C. Annual Cost Reports filed by carriers identified in Section 3 must contain, where applicable, all of the information in this subsection. For every carrier the report shall include the following information from the previous calendar year.
1. The information required in this report identified in paragraph 2 of this subsection C. must be itemized in the following categories by:
    - a. Market group size: individual, small group, and large group; and
    - b. Lines of business: comprehensive health insurance, Health Maintenance Organization (HMO) coverage, long term care, disability income, accident, specified or dread disease, hospital indemnity, vision, dental, Medicare supplement, and "other".
  2. The following information is to be reported from the carrier's annual financial statement or provided using the allocation method detailed in subsection D.:
    - a. Earned premium, not reduced by dividends;
    - b. Written premium, not reduced by dividends;

- c. Net reinsurance premiums;
  - d. Dividends;
  - e. Reserves on hand;
  - f. Net investment income;
  - g. The amount of surplus and the amount of surplus relative to the carrier's risk-based capital requirement;
  - h. Net income.
  - i. The cost of providing or arranging health care services;
  - j. Net reinsurance recoveries;
  - k. Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses;
  - l. Insurance producer commissions;
  - m. Payments to legal counsel;
  - n. Advertising and marketing expenditures;
  - o. General administrative expenses, including expenses that are not otherwise mentioned in this subsection; and
  - p. Staff salaries not reported in the annual financial statement's Supplemental Compensation Exhibit.
3. The following information may not be available in the annual financial statement and must be reported:
- a. The number of policyholders covered. This represents the number of actual policies issued for a product. For group coverage, this represents the number of primary subscribers to the groups and not the number of groups;
  - b. The number of groups covered;
  - c. The number of lives covered. This represents the number of individuals, including dependents that are covered under the policies or groups covered under a product type;
  - d. Paid lobbying expenditures;
  - e. Charitable contributions;
  - f. Healthcare cost trend must be itemized by product type as follows:
    - (1) Major Medical: This subsection shall be applicable for product types that provide comprehensive medical coverage, including but not limited to covering basic healthcare services and prescription drugs.

- (a) Medical trend, excluding pharmacy trend, itemized by provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology;
      - (b) Pharmacy trend, itemized by provider price increases, utilization changes, medical cost shifting and new brand and generic drugs.
    - (2) All other products: This subsection shall be applicable for all other product types not described in sub-subparagraph f.(1) of this paragraph 3. For each product type, the carrier shall report the trend applicable to the product for the prior year.
  - g. Provision for profit and contingencies;
  - h. Taxes itemized by category; and
  - i. Intermediaries. A list of each intermediary with whom the carrier has a contractual relationship, or a statement that the carrier does not have any intermediaries. Include entity/individual name, business address, and business phone number.
4. Executive salaries is defined to include, but is not limited to, base salary, bonuses and stock options reported on the carrier's Supplemental Compensation Exhibit of the annual financial statement. Carriers must provide:
- a. The Supplemental Compensation Exhibit of the carrier's annual financial statement; and
  - b. The percentage of executive salaries that should be allocated to Colorado health business.
- D. The information provided in subsection C. of this section shall be provided on a Colorado-only basis, with the exception of executive salaries as defined in subparagraph C.4.a. of this section. A carrier licensed in multiple jurisdictions may satisfy the requirements of subsection C. of this section by filing the Colorado-allocated portion of national data if the actual Colorado-only data is not otherwise available. The methods of allocation that should be used, if necessary, will be provided by the Division prior to the release of the report for completion.
- E. If any of the items listed in subsection C. of this section are not applicable to the carrier, the carrier shall indicate in the filing which items are not applicable and the reason why such items are not applicable.
- F. The information provided to the Division of Insurance in subsection C. of this section will be aggregated for all carriers and will be published on the Division of Insurance's website, [www.dora.colorado.gov/insurance](http://www.dora.colorado.gov/insurance).

## **Section 7      Annual Excess Loss Report**

- A. Pursuant to § 10-16-119(3), C.R.S., carriers subject to this regulation shall file an Annual Excess Loss Report as described in this section for each calendar year through 2018. This report must comply with the requirements of this section and must contain the information specified in subsection C. of this section and shall be filed electronically via a form provided on the Division of Insurance website, [www.dora.colorado.gov/insurance](http://www.dora.colorado.gov/insurance).

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

## **Section 8      Incorporated Materials**

FY 2014 Final Rule Tables, Table 5 published by the Centers for Medicare & Medicaid Services organization shall mean FY 2014 Final Rule Tables, Table 5 as published on the effective date of this regulation and does not include later amendments to or editions of FY 2014 Final Rule Tables, Table 5. A copy of FY 2014 Final Rule Tables, Table 5 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202, or by visiting the Centers for Medicare & Medicaid Services website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Tables.html>. A certified copy of FY 2014 Final Rule Tables, Table 5 may be requested from the Colorado Division of Insurance for a fee.

**Section 9 Severability**

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

**Section 10 Enforcement**

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

**Section 11 Effective Date**

This regulation shall become effective on August 1, 2015.

**Section 12 History**

New Regulation 4-2-31, Effective January 1, 2010.  
Amended Regulation, Effective August 1, 2011.  
Amended Regulation, Effective December 1, 2012.  
Amended Regulation, Effective November 15, 2013.  
Amended Regulation, Effective August 1, 2015.

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

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

**Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-135, C.R.S.

**Section 2 Scope and Purpose**

The purpose of this regulation is to define the standardized electronic identification and communication systems to be used by carriers and providers of health benefit plans in Colorado, as required by § 10-16-135, C.R.S.

**Section 3 Applicability**

This regulation applies to all health benefit plan providers and carriers operating in the state of Colorado. Deadlines imposed in this regulation may be extended by the Commissioner under the circumstances listed in subsection 5.G. of this regulation.

**Section 4        Definitions**

- A.        "Carrier" shall have the same meaning as in § 10-16-102(8), C.R.S.
- B.        "CORE" means the Committee on Operating Rules for Information Exchange.
- C.        "CORE Phase I certified" means having followed all CORE certification guidelines and received a Phase I certification seal.
- D.        "CORE Phase II certified" means having followed all CORE certification guidelines and received a Phase II certification seal.
- E.        "Health benefit plan" shall have the same meaning as in § 10-16-102(32), C.R.S.
- F.        "Provider" shall have the same meaning as in § 10-16-102(56), C.R.S.
- G.        "HIPAA" means Health Insurance Portability and Accountability Act of 1996.

**Section 5        Rules**

- A.        All carriers licensed in this state as of January 1, 2013, shall be able to show the ability of their systems to allow real time data exchange including benefits eligibility, coverage determinations, and other appropriate provider-carrier transactions and interoperability following all CORE guidelines for data formats and system requirements.
- B.        Carriers licensed in this state after January 1, 2013, if not already having systems that allow real time data exchange including benefits eligibility, coverage determinations, and other appropriate provider-carrier transactions following all CORE guidelines, shall, within sixty (60) days of becoming licensed adjust their systems to follow all CORE guidelines for data formats and system requirements.
- C.        CORE Phase I certification shall be accepted as evidence of compliance with subsections 5.A. and 5.B. Those carriers using CORE certification to comply with the provisions of this rule shall be required to become CORE Phase II certified within one (1) year of completing certification for CORE Phase I.
- D.        All carriers and providers shall uniformly use the Council for Affordable Quality Healthcare-developed CORE data content and infrastructure rules in the exchange of HIPAA compliant healthcare information and infrastructure improvements.
- E.        When installing new operating systems after December 31, 2012, all carriers are required to use CORE certified systems for communications, those systems which meet CORE certification standards, or contract with a vendor who has applied by January 1, 2013 to be CORE certified.
- F.        Notwithstanding the above requirements, those systems used solely for internal integrated systems between a carrier and a provider group may be granted an exemption from this requirement so long as CORE certification standards of systems that provide information exchange functionality for carrier interactions related to consumers, out of network providers, and non-dedicated providers is maintained. No exemption exists until the Commissioner has reviewed a written request for exemption and has made a written finding that the exemption is granted.

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

## **Section 6 Severability**

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

## **Section 7 Incorporated Materials**

The "CORE Phase I Eligibility and Benefits Operating Rules Manual" published by the Council for Affordable Quality Healthcare shall mean "CORE Phase I Eligibility and Benefits Operating Rules Manual" as published on the effective date of this regulation. It does not include later amendments to or editions of "CORE Phase I Eligibility and Benefits Operating Rules Manual". A copy of the "CORE Phase I Eligibility and Benefits Operating Rules Manual" may be examined at any state publications depository library. For additional information regarding how the "CORE Phase I Eligibility and Benefits Operating Rules Manual" may be obtained or examined, contact the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202.

The "CORE Phase II Policies and Operating Rules" published by the Council for Affordable Quality Healthcare shall mean "CORE Phase II Policies and Operating Rules" as published on the effective date of this regulation. It does not include later amendments to or editions of "CORE Phase II Policies and Operating Rules". A copy of the "CORE Phase II Policies and Operating Rules" may be examined at any state publications depository library. For additional information regarding how the "CORE Phase II Policies and Operating Rules" may be obtained or examined, contact the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202.

## **Section 8 Enforcement**

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

## **Section 9 Effective Date**

This regulation shall become effective on January 1, 2014.

## **Section 10 History**

New regulation effective October 1, 2010.  
Amended regulation effective July 1, 2012.  
Amended regulation effective January 1, 2014.

### **Regulation 4-2-33 MANDATORY OPEN ENROLLMENT PERIODS FOR CARRIERS ISSUING CHILD-ONLY PLANS [Repealed eff. 01/01/2014]**

### **Regulation 4-2-34 SECTION NAMES AND THE PLACEMENT OF THOSE SECTIONS IN POLICY FORMS BY HEALTH CARRIERS**

Section 1 Authority  
Section 2 Scope and Purpose



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

## **Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, and 10-16-137(1), C.R.S.

## **Section 2      Scope and Purpose**

The purpose of this regulation is to set forth the standardized format for section names and placement of those section names in policy forms issued by health carriers.

## **Section 3      Applicability**

The requirements and provisions of this regulation apply to health benefit plans, limited benefit health insurance, dental and vision policies issued or delivered on or after January 1, 2012.

This regulation does not apply to Medicare Supplement or disability income insurance.

## **Section 4      Definitions**

- A. "Health benefit plans" for the purposes of this regulation, shall have the same meaning as found at § 10-16-102(32), C.R.S.
- B. "Health carriers" for the purposes of this regulation, shall have the same meaning as found at § 10-16-102(8), C.R.S.
- C. "Limited benefit health insurance" means, for the purposes of this regulation, a health policy, contract or certificate offered or marketed as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments or coinsurance amounts not covered by a health benefit plan. "Limited benefit health insurance" does not include short-term limited duration health insurance policies, contracts or certificates; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan" as defined in § 10-16-102(32), C.R.S.

## **Section 5      Rules**

Health carriers shall use the following section names in the listed order, for health benefit plans, limited benefit health insurance, dental and vision policy forms:

- A. Section Names
  - 1. Schedule of Benefits (Who Pays What);
  - 2. Title Page (Cover Page);
  - 3. Contact Us;
  - 4. Table of Contents;

5. Eligibility;
  6. How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans);
  7. Benefits/Coverage (What is Covered);
  8. Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions);
  9. Member Payment Responsibility;
  10. Claims Procedure (How to File a Claim);
  11. General Policy Provisions;
  12. Termination/Nonrenewal/Continuation;
  13. Appeals and Complaints;
  14. Information on Policy and Rate Changes; and
  15. Definitions.
- B. Carriers may continue to use existing forms and instead publish a table of contents or directory which cross-references the proposed standards section names with those used in carrier's current forms.

#### **Section 6 Severability**

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

#### **Section 7 Enforcement**

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

#### **Section 8 Effective Date**

This regulation is effective January 1, 2014.

#### **Section 9 History**

New Regulation effective October 1, 2011.  
Amended Regulation effective January 1, 2014.

#### **Regulation 4-2-35 REQUIRED INFORMATION FOR CARRIERS TO PROVIDE ON EXPLANATION OF BENEFITS FORMS**

- |           |                   |
|-----------|-------------------|
| Section 1 | Authority         |
| Section 2 | Scope and Purpose |
| Section 3 | Applicability     |
| Section 4 | Definitions       |

Section 5	Rules
Section 6	Protected Health Information
Section 7	Severability
Section 8	Enforcement
Section 9	Effective Date
Section 10	History

## **Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-137(2), C.R.S.

## **Section 2      Scope and Purpose**

The purpose of this regulation is to set forth the minimum required information for health carriers to provide on an explanation of benefits form sent to covered persons or providers.

## **Section 3      Applicability**

The requirements and provisions of this regulation apply to health benefit plans, limited benefit health insurance, and dental plans issued or delivered on or after January 1, 2012.

This regulation does not apply to Medicare Supplement or disability income insurance.

## **Section 4      Definitions**

- A. "Health benefit plans" for the purposes of this regulation, shall have the same meaning as found at § 10-16-102(32), C.R.S.
- B. "Health carriers" for the purposes of this regulation, shall have the same meaning as found at § 10-16-102(8), C.R.S.
- C. "Limited benefit health insurance" for the purposes of this regulation, means a health policy, contract or certificate marketed as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments or coinsurance amounts not covered by a health benefit plan. "Limited benefit health insurance" does not include short-term limited duration health insurance policies, contracts of certificates; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan" as defined in § 10-16-102(32), C.R.S.

## **Section 5      Explanation of Benefits Form Information**

Health carriers shall include the following information on an explanation of benefits (EOB) form sent to covered persons or providers:

- A. Name of member.
- B. Relationship of member to subscriber.
- C. Subscriber/member's claim number.
- D. Name of subscriber.
- E. Provider name and whether the provider is in or out of network.

- F. Date of service.
- G. Type of service (emergency, inpatient, outpatient, etc.).
- H. Denial information (with enough specificity to enable the member/subscriber to determine the reason for the denial). Additionally, a notice will need to go out with the denial: "Notice: The diagnosis and treatment codes (and their meaning) related to the service that is the subject of this Explanation of Benefits (EOB) are available upon request made to the carrier."
- I. Carrier contact information.
- J. Explanation of appeal rights (Can be an attachment to EOB).
- K. Notice "THIS IS NOT A BILL".
- L. Claim payment calculation.
  - 1. Financial Information:
    - a. Total billed amount; and
    - b. Amount allowed under the policy (if amount was less than billed amount include explanation: i.e. discounted due to network agreement, carrier's determination of reasonable and customary, out of network provider).
  - 2. Breakdown of policy's cost-sharing requirements:
    - a. Subscriber/member's deductible amounts;
    - b. Subscriber/member's coinsurance amount or out-of-pocket amounts; and
    - c. Subscriber/member's copayment amounts.
- M. Subscriber/member's financial liability.
  - 1. "What you owe" (deductible + coinsurance + copayment); and
  - 2. "What we will pay".
- N. Status of policy deductible, out-of pocket amount, and policy maximums.
  - 1. All deductible amounts applied to date;
  - 2. All coinsurance amounts or out-of-pocket amounts applied to date, if applicable; and
  - 3. Policy maximum amount, if applicable (annual out-of-pocket maximum or in the case of limited benefit plans, any annual limits for a specific benefit).

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**Section 6      Protected Health Information**

Carriers must take reasonable steps to ensure that the protected health information (PHI) of any adult child or adult dependent who is covered under the policy is protected. This protection includes ensuring that any communications between the carrier and covered adult child remain confidential and private, as required under the Health Insurance Portability and Accountability Act (HIPAA). This protection of personal health information would include, but is not limited to, developing a means of communicating exclusively with the covered adult child or adult dependent such that PHI would not be sent to the policyholder without prior consent of the covered adult child or adult dependent.

**Section 7      Severability**

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

**Section 8      Enforcement**

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

**Section 9      Effective Date**

This regulation is effective January 1, 2014.

**Section 10     History**

New Regulation effective October 1, 2011.  
Amended Regulation effective January 1, 2014.

**Regulation 4-2-36      PRESCREENING QUESTIONNAIRE FOR INDIVIDUAL HEALTH BENEFIT PLANS [Repealed eff. 12/01/2013]**

**Regulation 4-2-37      REQUIRED INFORMATION FOR CARRIERS TO OBTAIN ON ALL FULL-LENGTH APPLICATIONS FOR INDIVIDUAL HEALTH BENEFIT PLANS**

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

**Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-16-105.2(1.5), C.R.S.

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**Section 2      Scope and Purpose**

The purpose of this regulation is to establish a standard affidavit form to be used upon application for an individual health benefit plan when a small employer intends on reimbursing an employee for any portion of the premium.

**Section 3      Applicability**

The requirements of this regulation apply to all carriers issuing individual health benefit plans. It does not apply to applications for limited benefit health insurance plans or to applications for short-term health benefit plans.

**Section 4      Definitions**

- A. "Carrier" 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. "Limited benefit health insurance" for the purposes of this regulation, means a health policy, contract or certificate marketed as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments or coinsurance amounts not covered by a health benefit plan. "Limited benefit health insurance" does not include short-term limited duration health insurance policies, contracts of certificates; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan" as found at § 10-16-102(32), C.R.S.
- D. "Short-term health benefit plans" shall have the same meaning as found at §10-16-102(60) C.R.S.

**Section 5      Rules**

- A. All full-length applications for individual health benefit plans must contain the questions provided in Appendix A, as supplemental form with a separate applicant signature.
- B. If an applicant for an individual health benefit plan is required to submit an affidavit executed by the employer, the affidavit in Appendix B must be used.
  - 1. The affidavit form must have been executed by the employer no earlier than ninety (90) calendar days prior to, or no later than ninety (90) calendar days after, the submission of the individual application to the carrier.
  - 2. If the affidavit is beyond the ninety (90) calendar day time period, the carrier shall require a new affidavit be submitted with the full-length application.

**Section 6      Severability**

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

**Section 7      Enforcement**

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

**Section 8      Effective Date**

This regulation shall become effective on November 1, 2013.

**Section 9      History**

Emergency regulation E-11-04 effective May 19, 2011.

New regulation effective September 1, 2011.

Amended regulation effective November 1, 2013.

**Appendix A:    Required questions for full-length applications for individual health benefit plans.**

1.      Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

If you answered "yes", please continue. If you answered "no", you may stop.

2.      Did the employer have a small group health benefit plan providing coverage to any employee in the twelve (12) months prior to the date of this application?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

3.      If the answer to both questions 1 and 2 is "yes", the applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

If the answer to question 1 is "yes" and the answer to question 2 is "no", the applicant must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months.

The affidavit form to be executed by the employer is attached. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

**Appendix B:    Form of Affidavit**

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

\_\_\_\_\_

The undersigned officer or principal of the employer identified above certifies that:

1.      The employer is a small employer as defined in § 10-16-102(61), C.R.S., with fifty (50) or fewer eligible employees;
2.      The employer has not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit.
3.      A false certification may cause the rescission of the employee's individual insurance policy and subject the employer to penalties for perjury and liability to the employee.

Signed: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Position: \_\_\_\_\_

Date: \_\_\_\_\_

**Regulation 4-2-38      CONTRACEPTIVE BENEFITS**

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

**Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-104(3)(a)(I) C.R.S.

**Section 2      Scope and Purpose**

The purpose of this regulation is to implement Colorado insurance law and ensure carriers are providing coverage for contraception in policies in the same manner as any other sickness, injury, disease or condition is otherwise covered under the policy or contract.

**Section 3      Applicability**

The requirements and provisions of this regulation apply to all group sickness and accident insurance policies and health service contracts issued to an employer and all individual sickness and accident, health care or indemnity contracts under parts 2, 3 or 4 of Title 10.

This regulation does not apply to supplemental policies covering a specified disease or other limited benefits under § 10-16-102(21)(b), C.R.S.

**Section 4      Definitions**

For purposes of this regulation, the following terms are defined:

- A. "Contraceptive" or "contraception" means a medically acceptable drug, device, or procedure used to prevent pregnancy in accordance with § 2-4-401, C.R.S.
- B. "Emergency contraception" means a drug approved by the federal food and drug administration that prevents pregnancy after sexual intercourse, including but not limited to oral contraceptive pills; except that "emergency contraception" shall not include RU-486, mifepristone, or any other drug or device that induces a medical abortion, in accordance with § 25-3-110, C.R.S.
- C. "Prescription drug" shall have the same meaning as defined in § 12-22-102(30), C.R.S.



## **Section 5      Rules**

All group sickness and accident insurance policies and health service contracts issued to an employer and all individual sickness and accident insurance, health care or indemnity contracts shall provide contraceptive benefits in the same manner as any other sickness, injury, disease or condition is otherwise covered under the policy or contract.

- A. Policies or contracts with prescription drug benefits shall cover prescription contraceptive drugs in the same manner as other prescription drugs are covered under the policy or contract. However, over-the-counter contraceptive drugs or devices for which a prescription is not required and which are not otherwise covered under the policy or contract, are not required to be covered.
- B. Voluntary sterilization procedures are covered as a health care service as defined in § 10-16-102(22), C.R.S., in the same manner as any other sickness, injury, disease or condition is otherwise covered under the policy or contract.
- C. Hormone injections for contraception shall be covered in the same manner as hormone injections for any other sickness, injury, disease or condition.
- D. Emergency contraception is covered in the same manner as any other drug or device for any other sickness, injury, disease or condition is otherwise covered under the policy or contract.
- E. The drugs RU-486, mifepristone, or any other drug or device that induces a medical abortion are not contraceptives or emergency contraceptives within the definitions of such terms and are not required to be covered under a contraceptive benefit.
- F. Intrauterine devices (IUDs), subdermal implants, and the insertion, management and removal of such devices are covered in the same manner as health care services as defined in § 10-16-102(22), C.R.S. and devices as defined in § 12-22-102(8), C.R.S. to treat any other sickness, injury, disease or condition are otherwise covered under the policy or contract.

## **Section 6      Severability**

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

## **Section 7      Enforcement**

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

## **Section 8      Effective Date**

This regulation shall become effective on January 1, 2012.

## **Section 9      History**

New regulation effective January 1, 2012.

**Regulation 4-2-39      CONCERNING PREMIUM RATE SETTING FOR NON-GRANDFATHERED  
INDIVIDUAL, SMALL AND LARGE GROUP HEALTH BENEFIT PLANS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	General Rate Filing Requirements
Section 6	Actuarial Memorandum
Section 7	Premium Rate Setting for Individual and Small Group Health Benefit Plans
Section 8	Rate Filings and Actuarial Certification for Small Group Health Benefit Plans
Section 9	Additional Requirements for Large Group Health Benefit Plans
Section 10	Prohibited Rating Practices
Section 11	Use of Composite Rating in the Small Group Market
Section 12	Incorporation by Reference
Section 13	Severability
Section 14	Enforcement
Section 15	Effective Date
Section 16	History
Appendix A	Rate Filing Requirements for Non-grandfathered individual and small group health benefit plans
Appendix B	Sample Rate Table

**Section 1      Authority**

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

**Section 2      Scope and Purpose**

The purpose of this regulation is to provide the necessary guidance to carriers to implement the requirements of House Bill 13-1266, enacted during the 2013 General Assembly and to ensure that health insurance rates comply with Colorado's health benefit plan rating laws.

**Section 3      Applicability**

This regulation applies to all carriers marketing and issuing non-grandfathered individual, small group, and/or large group health benefit plans on or after January 1, 2014; health benefit plans subject to the individual, small group, and large group laws of Colorado; and stand-alone dental plans that provide for pediatric dental as an essential health benefit. This regulation excludes individual short-term policies as defined in § 10-16-102(60), C.R.S.

**Section 4      Definitions**

- A. "Benefits ratio" means, for the purposes of this regulation, the ratio of the value of the actual policy benefits, not including policyholder dividends, to the value of the actual premiums, not reduced by policyholder dividends, over the entire period for which rates are computed to provide coverage. Additionally, the Division of Insurance (Division) will consider Quality Improvement (QI), as defined herein at Section 4.AA. in the benefits ratio calculation. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits ratio calculations must be displayed without the inclusion of active life reserves.

- B. "Carrier" means, for the purposes of this regulation, a carrier as found at § 10-16-102(8), C.R.S., and includes, but is not limited to: licensed life and health insurance companies; non-profit hospital, medical-surgical, and health service corporations; health maintenance organizations (HMOs); prepaid dental companies; and limited service licensed provider networks.
- C. "Catastrophic plan" shall have the same meaning as found at § 10-16-102(10), C.R.S.
- D. "Covered lives" means, for the purposes of this regulation, the number of members, subscribers and dependents.
- E. "Dividends" means, for the purposes of this regulation, both policyholder and stockholder dividends.
- F. "Essential health benefit" and "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.
- G. "Excessive rates" means, for the purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided, or if the rates include a provision for expenses that is unreasonably high in relation to the services rendered. In determining if the rate is excessive, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a rate filing.
- H. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.
- I. "File and use" means, for the purposes of this regulation, a filing procedure that requires rates and rating data to be filed with the Division concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates. Under no circumstance shall the carrier provide insurance coverage using the rates until on or after the proposed implementation or effective date specified in the rate filing. Carriers may bill members but not require the member to remit premium prior to the proposed implementation or effective date of the rate change.
- J. "Filing date" means, for the purposes of this regulation, the date that the rate filing is received at the Division.
- K. "Filed rate" means, for the purposes of this regulation, the index rate as adjusted for plan design and the case characteristics of age, geographic location, tobacco use and family size only. The "filed rate" does not include the index rate as further adjusted for any other case characteristic. (See Section 7.A.3. of this regulation.)
- L. "Geographic area" means, for the purposes of this regulation, the geographic area selected by Colorado and approved by the federal government, to be used by carriers in the state of Colorado.
- M. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.
- N. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

- O. "Implementation date" means, for the purposes of this regulation, the date that the filed or approved rates can be charged to an individual or group.
- P. "Index rate" shall have the same meaning as found at § 10-16-102(39), C.R.S.
- Q. "Inadequate rates" means, for the purposes of this regulation, rates that are clearly insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a rate filing.
- R. "Multistate associations" shall have the same meaning as found at § 10-16-102(68), C.R.S.
- S. "New policy form or product" means, for the purposes of this regulation, a policy form that has substantially different new benefits or unique characteristics associated with risk or costs that are different from existing policy forms. For example: A guaranteed issue policy form is different than an underwritten policy form; a managed care policy form is different than a non-managed care policy form; a direct written policy form is different from a policy sold using producers, etc.
- T. "Plan" means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.
- U. "PPACA" or "ACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.
- V. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.
- W. "Premium rate" means, for the purposes of this regulation, all moneys paid by an individual, or an employer and eligible employees, as a condition of receiving coverage from a carrier, including any fees or other contributions associated with obtaining or administering the health benefit plan.
- X. "Prior approval" means, for the purposes of this regulation, a filing procedure that requires a rate change be affirmatively approved by the commissioner prior: to distribution, release to producers, collection of premium, advertising, or any other use of the rate. Under no circumstances shall the carrier provide insurance coverage using the rates until on or after the proposed implementation or effective date specified in the rate filing. The implementation date must be at least sixty (60) days after the date of submission. After the rate filing has been approved by the commissioner, carriers may bill members but not require the member to remit premium prior to the proposed implementation or effective date of the rate change.
- Y. "Product(s)" means, for the purposes of this regulation, the services covered as a package under a policy form developed by a carrier, which may have several cost-sharing options and riders as options.
- Z. "Qualified actuary" means, for the purposes of this regulation, a member of the American Academy of Actuaries, or a person who has demonstrated to the satisfaction of the commissioner that the person has sufficient educational background and who has not less than seven (7) years of recent actuarial experience relevant to the area of qualifications, as defined in Colorado Insurance Regulation 1-1-1.

- AA. “Quality improvement expenses” and “QI” mean, for the purposes of this regulation, expenses, other than those billed or allocated by a provider for health care delivery (i.e., clinical or claims costs), for all carrier activities that are designed to improve health care quality, and increase the likelihood of desired health outcomes, in ways that are capable of being objectively measured and produce verifiable results and achievements. These expenses must be directed toward enrollees, or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees participation other than allowable QI associated with self-insured plans. Qualifying QI shall be grounded in evidence-based medicine, widely accepted best clinical practices, or in criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. Qualifying QI activities should not be designed primarily to control or contain cost, though they may have cost-reducing or cost-neutral benefits if quality improvement remains the primary goal and are primarily designed to achieve the following goals:
1. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
  2. Prevent hospital readmissions;
  3. Improve patient safety and reduce medical errors, lower infection and mortality rates;
  4. Increase wellness and promote health activities; or
  5. Enhance the use of health care data to improve quality, transparency, and outcomes.
- AB. “Rate” means, for the purposes of this regulation, the amount of money a carrier charges as a condition of providing health coverage. The rate charged normally reflects such factors as the carrier’s expectation of the insured’s future claim costs; the insured’s share of the carrier’s claim settlement; operational and administrative expenses; and the cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the contract. Rates for all health benefit plans and pediatric dental plans must be filed with the Division.
- AC. “Rate filing” means, for the purposes of this regulation, a filing that contains all of the items required in this regulation, and:
1. For individual products, the proposed base rates and all rating factors. The underlying rating assumptions must be submitted. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of previously filed trend factors. Support for new product offerings must be provided; and
  2. For group products, proposed base rates, the underlying rating factors and assumptions. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of previously filed trend factors. Support for new product offerings must be provided. Groups must meet the definition contained in §§ 10-16-214(1) and 10-16-215, C.R.S.
- AD. “Rate increase” shall have the same meaning as found at § 10-16-102(57), C.R.S., and includes increases in any current rate or factor used to calculate rates for new or existing policyholders, members, or certificate holders. Rate changes applicable to “new business only” are considered rates changes, and must be supported. Rate increases for “new business only” are subject to prior approval.
- AE. “Rating period” shall have the same meaning as found at § 10-16-102(58), C.R.S.

- AF. “Renewed” means, for the purposes of this regulation, a plan renewed upon the occurrence of the earliest of: the annual anniversary date of issue; the date on which premium rates can be or are changed according to the terms of the plan; or the date on which benefits can be or are changed according to the terms of the plan. If the plan specifically allows for a change in premiums or benefits due to changes in state or federal requirements, and a change in the health benefit and standalone pediatric dental plan premiums or benefits that is solely due to changes in state or federal requirements, and is not considered a renewal in the plan, then such a change will not be considered a renewal for the purposes of this regulation.
- AG. “Retention” means, for the purposes of this regulation, the sum of all non-claim expenses including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses as the percentage of total premium.
- AH. “SERFF” means, for the purposes of this regulation, System for Electronic Rate and Form Filings.
- AI. “Substantially different new benefit” means, for the purposes of this regulation, a new benefit which results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product does not create a new benefit. Actuarial value is the change in benefit cost as developed when making other benefit relativity adjustments.
- AJ. “Trend” or “trending” means, for the purposes of this regulation, any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing. Trend used solely for restating historical experience from the experience period to the rating period, or which is used to project morbidity, is considered a rating assumption.
- AK. “Trend factors” means, for the purposes of this regulation, rates or rating factors which vary over time or due to the duration that the insured has been covered under the policy or certificate, and which reflect any of the components of medical or insurance trend assumptions used in pricing. Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and technology. Insurance trend includes the effect of underwriting wear-off, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Rate filings must be submitted on an annual basis to support the continued use of trend factors. Underwriting wear-off does not apply to guaranteed issue products.
- AL. “Unfairly discriminatory rates” means, for the purposes of this regulation, charging different rates for the same benefits provided to individuals, or groups, with like expectations of loss; or if after allowing for practical limitations, differences in rates which fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.
- AM. “Use of the rates” means, for the purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder including advertising, distributing rates or premiums to producers and disclosing premium quotes. Rates must be filed with the Division and forms, as required by § 10-16-107.2, C.R.S., must be filed prior to use. It does not include releasing information about the proposed rate change to other government entities or disclosing general information about the rate change to the public.

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

## **Section 5 General Rate Filing Requirements**

All rates associated with health coverage policies, riders, contracts, endorsements, certificates, and other evidence of health coverage associated with health benefit plans and standalone pediatric dental plans must be filed with the Division prior to issuance or delivery of coverage. All rate filings shall be submitted electronically by licensed entities. Failure to supply the information required in Sections 5., 6., 7., 8. and 9. of this regulation will render the filing incomplete. Incomplete filings are not reviewed for substantive content. All filings that are not returned or disapproved on or before the 30th calendar day after receipt will be considered complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be identified and communicated to the filing carrier on or before the 45th calendar day after receipt. Correction of any deficiency, including deficiencies identified after the 45th calendar day, will be required on a prospective basis, and no penalty will be applied for a non-willful violation identified in this manner, other than as allowed by § 10-16-216.5, C.R.S. Nothing in this regulation shall render a rate filing subject to prior approval by the commissioner that is not otherwise subject to prior approval as provided by statute.

### **A. General Requirements**

1. Prior Approval: Any proposed rate increase for health benefit plans or a rate increase of 5% or more annually for dental insurance is subject to prior approval by the commissioner and must be filed with the Division at least sixty (60) calendar days prior to the proposed implementation or use of the rates.
  - a. If the commissioner approves the rate filing within sixty (60) calendar days after the filing date, the carrier may use the rates immediately upon approval for new business and upon renewal for existing business; however, under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation or effective date specified in the rate filing.
  - b. A carrier who provides insurance coverage using the rates before the proposed implementation or effective date will be considered as using unfiled rates and the Division will take appropriate action as defined by Colorado law.
  - c. After the rate filing has been approved by the commissioner, carriers may bill members, but not require the member to remit premium prior to the proposed implementation date of the rate change.
  - d. If the commissioner does not approve or disapprove the rate filing within sixty (60) calendar days after the submission date, the carrier may use the rates as of the implementation or effective date in the filing.

- e. Under no circumstances shall the carrier provide insurance coverage under the filed rates until on or after the proposed implementation date or effective date specified in the rate filing.
- 2. Existing law defines a rate increase as any increase in the current rate. This, for purposes of this regulation, includes an increase in any base rate, or any rating factor, or continued use of trend factors used to calculate premium rates which results in an overall increase in the current rate to any existing policyholder or certificate holder renewing during the proposed rating period of the filing and would be considered a prior approval filing. Rate increases as applied to “new business only” are also subject to prior approval.

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

The commissioner may require submission of any relevant information the commissioner deems necessary in determining whether to approve or disapprove a rate filing. Corrections of any deficiency identified after the 60th calendar day will be required on a prospective basis and no penalty will be applied for a non-willful violation identified in this manner if the rates are determined to be excessive, inadequate or unfairly discriminatory, other than as allowed by § 10-16-216.5, C.R.S.

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

- a. The benefits provided are not reasonable in relation to the premiums charged;
  - b. The rate filing contains rates that are excessive, inadequate, unfairly discriminatory, or otherwise does not comply with the provisions of Sections 5., 6., 7., 8., 9. and 10. of this regulation. In determining if the rate is excessive or inadequate, the commissioner may consider profits, dividends, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice;
  - c. The actuarial reasons and data do not justify the requested rate increase;
  - d. The rate filing is incomplete; or
  - e. The data in the filing failed to adequately support the proposed rates.
- 3. File and Use: Any rate filing not specified in Paragraph 1 of this subsection is classified as file and use. Existing law allows for file and use rate filings to be implemented upon submission to the Division and correction of any deficiency shall be on a prospective basis. All filings not returned on or before the 30<sup>th</sup> day after submission to the Division will be considered complete. Rates for all health coverages must be filed with the Division prior to use.



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

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

4. New Policy Forms and Products: Carriers shall not represent an existing product to be a new policy form, or product unless it fits the definition set forth in Section 4.S. If a policy form is not a new policy form or product, and the rate is increasing, the rate filing will be considered a prior approval filing and the required supporting documentation required by law and regulation will need to be submitted with the filing. In the case of reasonable modifications, pursuant to § 10-16-105.1, C.R.S., if an existing policy form is modified and it is truly not a new policy form or product, the policy form must be revised to comply with the provisions of § 10-16-105.1, C.R.S.
5. Required Submissions:
  - a. Rates on all health insurance policies, riders, contracts, endorsements, certificates, and other evidence of health coverage, must be filed with the Division prior to issuance or deliverance of policies, certificates or evidence of coverage.
  - b. All carriers must submit a compliant rate filing whenever the rates charged to new or renewing policyholders, or certificate holders differ from the rates on file with the Division. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in trend or other rating assumptions. Failure to file a rate filing that is compliant with this regulation in these instances will render the carrier as using unfiled rates and the Division will take appropriate action as allowed by Colorado law.
  - c. All carriers must submit a compliant rate filing on an annual basis, at minimum, to support the continued use of trend factors, which change on a predetermined basis. The rate filing must contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate. The rate filing shall contain all of the items required in this regulation. The rate filing must demonstrate that the rate is not excessive, inadequate or unfairly discriminatory. Note: Trend factors which change on a predetermined basis can be continued for no more than twelve (12) months. To continue the use of trend factors that change on a predetermined basis, a filing must be made for that particular form with an implementation or effective date on or before the one-year anniversary of the implementation or effective date of the most recent rate filing for that form.

- d. All carriers must submit compliant rate filings when rates are changed on an existing product, even though the rate change pertains to new business only. Colorado experience data for this existing product must be submitted. If Colorado data is partially credible, nationwide data must also be submitted. Detailed support must be provided for the rate change. Support must also be provided to ensure rates are not discriminatory. Assessing different rates for the same product based on issue dates may violate Colorado law.
  - e. All carriers must submit compliant rate filings within sixty (60) calendar days after commissioner approval of the assumption or acquisition of a block of business. This rate filing should provide detailed support for the rating factors the assuming or acquiring carrier is proposing to use, even if there is no change in rating factors. The new filing must demonstrate that the rating assumptions are still appropriate.
  - f. Each line of business requires a separate rate filing. Rate filings should not be combined with form filings.
  - g. All carriers are expected to review their experience on a regular basis, no less than annually, and file rate revisions, as appropriate, in a timely manner to ensure that rates are not excessive, inadequate and unfairly discriminatory, and to avoid filing large rate changes
  - h. The Form Schedule tab in SERFF must be completed for all rate and form filings. This tab must list policies, riders, endorsements, or certificates referenced in the rate filing. Do not attach the actual forms to a rate filing.
6. Withdrawn, Returned, or Disapproved Filings: Filings that have been withdrawn by the filer, returned by the Division as incomplete or disapproved as unjustified, and are subsequently resubmitted, will be considered as new filings. If a filing is withdrawn, returned, or disapproved, those rates may not be used or distributed. Nothing in this regulation shall render a rate filing subject to prior approval by the commissioner which is not otherwise subject to prior approval as provided by Colorado law.
7. Submission of Rate Filings: All health benefit plans and stand-alone pediatric dental plan rate filings must be filed electronically in a format made available by the Division, unless exempted by rule for an emergency situation as determined by the commissioner. If the carrier fails to comply with these requirements, the carrier will be notified that the filing has been returned as incomplete. Complete electronically submitted rate filings must meet all relevant general requirements, including all necessary rate and policy forms. If a filing is returned as incomplete, those rates may not be used or distributed.
8. Carrier Specific: A separate filing must be submitted for each carrier. A single filing made for more than one carrier, or for a group of carriers is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan.

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

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

10. Confidentiality: All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. The Division does not consider such items as rates, rating factors, rate histories, or side-by-side comparisons of rates or retention components to be confidential. The entire filing, including the actuarial memorandum, cannot be held as confidential. There should be separate SERFF component for the confidential exhibits, and must be indicated by the icon as confidential in SERFF. Non-confidential information, such as the actuarial memorandum, must be in a separate SERFF component.
11. A "Confidentiality Index" must be completed if the carrier desires confidential treatment of any information submitted, as required in this regulation. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected. It should be noted that HMOs are not afforded automatic confidential treatment of any rate filings; and, therefore, must complete a Confidentiality Index.
12. Premium rounding and truncation rules shall be provided with all rated filings.
13. Rating factors must be calculated and displayed to four decimal points.

**B. Actuarial Certification**

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

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

"This policy DOES NOT include coverage of pediatric dental services as required under the Affordable Care Act. Coverage of pediatric dental services is available for purchase in the State of Colorado and can be purchased as a stand-alone plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage or an Exchange-qualified stand-alone dental plan that includes pediatric dental coverage."

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

## **Section 6 Actuarial Memorandum**

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

- A. Summary: The memorandum must contain a summary that includes, but is not limited to, the following:
1. Reason(s) for the rate filing: A statement as to whether or not this is a new product offering; a rate revision to an existing product, which includes rates applicable to “new business only”, or; a new option being added to an existing form. If the filing is a rate revision, the reason for the revision should be clearly stated.
  2. Requested Rate Action: The overall rate increase or decrease should be listed. The listed rate change, the average change in each rate component and the change in renewal date by effective month must be provided. The submission must also list the twelve (12) month renewal with changes by component and the averages by component.
  3. Marketing Method(s): A brief description of the marketing method used for the filed form should be listed. (Agency/Broker, Internet, Direct Response, Other) All non-employer groups must be clearly identified, and must meet the definition of a “valid group” found in this regulation.
  4. Premium Classification: This section should state all attributes upon which the premium rates vary. This section must comply with all new rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.
  5. Product Descriptions: This section should describe the benefits provided by the policy, rider or contract. For non-grandfathered individual and small group health benefit plans and stand-alone pediatric dental, this section must include EHB(s) and list any substitution of benefits or any additional benefits provided above the required EHB(s).
  6. Policy/Rider or Contract: This section must include a listing of all policies/riders or contracts impacted by the submission.
  7. Age Basis: This section must state whether the premiums will be charged on an attained age, renewal age or other basis.
  8. Renewability Provision: All health benefit plans are guaranteed renewable.

A1: SUMMARY	
<b>1. Reason(s):</b>	<input type="checkbox"/> Experience <input type="checkbox"/> Trend <input type="checkbox"/> New Product <input type="checkbox"/> New Benefits <input type="checkbox"/> Other:
<b>2. Requested Rate Action:</b>	<input type="checkbox"/> Base Rate Change _____% <input type="checkbox"/> Trend _____% <input type="checkbox"/> Benefit Factor Change _____% <input type="checkbox"/> Area Factor Change _____% <input type="checkbox"/> Other: _____% <input type="checkbox"/> Average Total Change _____% <input type="checkbox"/> Minimum _____% <input type="checkbox"/> Maximum _____%
<b>3. Marketing Method(s):</b>	<input type="checkbox"/> Agency/Broker <input type="checkbox"/> Internet <input type="checkbox"/> Direct Response <input type="checkbox"/> Other:
<b>4. Premium Classification(s):</b>	<input type="checkbox"/> Age <input type="checkbox"/> Family Composition <input type="checkbox"/> Tobacco <input type="checkbox"/> Geographic Area <input type="checkbox"/> Benefit <input type="checkbox"/> Other: _____
<b>5. Product Description(s):</b>	
<b>6. Policy/Rider Impacted:</b>	Form _____ Form _____ Form _____
<b>7. Age Basis:</b>	<input type="checkbox"/> Renewal Age <input type="checkbox"/> Attained Age <input type="checkbox"/> Both Issue & Attained Age <input type="checkbox"/> Not utilized Other: _____
<b>8. Renewability Provision:</b>	
<b>Additional Information:</b>	

A2: RATE CHANGE DISTRIBUTION*		
Rate Increase	Distribution	Members
< 0%	XX.XX%	X,XXX
0 – 4%	XX.XX%	X,XXX
4 – 8%	XX.XX%	X,XXX
8 – 12%	XX.XX%	X,XXX
12 – 16%	XX.XX%	X,XXX
16 – 20%	XX.XX%	X,XXX
> 20%	XX.XX%	X,XXX

\* Chart A2: Rate Change Distribution must be provided in an Excel spreadsheet

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

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

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

1. Individual Market: The rating period must be twelve (12) months and premiums cannot change through the year.
2. Small Group Market: An annual rate filing must be made each year with an effective date of January 1. Rating period may be no more than twelve (12) months. Rates in the annual filing may be trended quarterly. Quarterly filings may be made with an effective date of April 1, July 1, and October 1 only.

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

- D. Effect of Law Changes: The memorandum should identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable mandates should be listed, including those with no rating impact. This quantification must include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

<b>D. EFFECT OF LAW CHANGES</b>	
<b>Identify and quantify changes resulting from mandated benefits and other law changes:</b>	
<b>Select N/A if no changes</b>	<input type="checkbox"/> N/A
<b>Additional Information:</b>	

- E. Rate History: The memorandum must include a chart showing, at a minimum, any rate changes that have been implemented in the three (3) years immediately prior to the filing date, including the implementation date of each rate change.
1. This chart must contain the following information: the filing number (State or SERFF tracking number), the implementation date of each rate change, the average increase or decrease in rate, the minimum and maximum increase and cumulative rate change for the past twelve (12) months.
  2. This chart must contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.
  3. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable. This must be provided in an Excel spreadsheet.

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

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

<b>F: COORDINATION OF BENEFITS</b>	
<b>Provides actual loss experience net of any savings:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Additional Information:</b>	

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

1. All rate filings justifying the relationship of benefits to premium using one of these guidelines must list the components of the retention percentage.
2. The Division-recommended benefit ratio guidelines are as listed below. Targeted loss ratios below these guidelines shall be actuarially justified.

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

<b>G: Relation of Benefits to Premium</b>	
This must be provided in an Excel spreadsheet	
<b>Description</b>	<b>Percentage</b>
<b>Commissions</b>	
<b>General expenses</b>	
<b>Premium taxes</b>	
<b>Federal Income Tax</b>	
<b>Profit/Contingencies</b>	
<b>Investment Income</b>	
<b>PPACA Fees</b>	
<b>Health Insurer Fee</b>	
<b>PCORI</b>	
<b>Reinsurance Fee*</b>	
<b>Risk Adjustment*</b>	
<b>Exchange Fees</b>	
<b>Quality Improvement</b>	
<b>Other</b>	
<b>Total Retention</b>	
Targeted Loss Ratio (This number should equal 1 minus the total retention percentage listed above)	

\*Only applicable to years in which Federal agencies maintain these programs

H. Federal Medical Loss Ratio.



Provide a calculation of the estimated federal medical loss ratio (MLR) for the two most recent completed calendar years. For example, a filing for calendar year 2017 should contain the MLR calculation for calendar years 2013 and 2014.

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

I. Provision for Profit and Contingencies.

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

<b>I. PROVISION FOR PROFIT AND CONTINGENCIES</b>	
If material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process.	
1 Post-Tax Provision for Profit and Contingencies:	x.x%
2. Federal Income Tax	x.x%
3. Pre-tax Provision for Profit and Contingencies (3 = (1) + (2))	x.x%
4. Investment Income (expressed as a negative number)	x.x%
5. Pre-tax Profit and Contingencies, including Investment Income (5 = (3) + (4))	x.x%

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

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

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

1. Index Rate Development
  - a. Carriers must develop a market-wide index rate based on the total combined EHB claims experience of all enrollees in all non-grandfathered (NGF) plans in the respective individual and small group single risk pool.
  - b. After setting the Index Rate, the carrier shall make a market-wide adjustment based on the expected aggregated payments and charges under the risk adjustment and reinsurance programs in Colorado.
  - c. The premium rate for any given plan shall not vary from the resulting adjusted market-wide Index Rate, except for the following factors: The actuarial value and cost-sharing structure of the plan; the plan's provider network; delivery system

characteristics; utilization management practices; plan benefits in addition to EHB; and with respect to catastrophic plans, the expected impact of specific eligibility categories for those plans.

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

2. Geographic Factor

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

3. Benefit Factor

Complete explanation as to how benefit factors were developed. Differences in the rates for different benefit plans, for persons with the same case characteristics of age, geographic location, family size, and tobacco use shall be attributable to plan design only. Benefit factors should not reflect the health status of members assumed to be enrolled in any particular plan, and should not reflect claims experience of members on a particular plan. The benefit cost relativity between plans should only reflect the true benefit differences due to different member cost sharing levels and plan design features. Using this method, a carrier's benefit factor for a plan design relative to the benefit factor for a richer (leaner) plan design should be higher (lower).

4. Morbidity

Other projected population changes from the experience period to the rating period should include considerations of newly insureds entering the market, grandfathered members moving into NGF products, and members moving from high-risk pools into commercial plans.

5. Other Factors (Dental and Large Group only)

The memorandum must clearly display or clearly reference all other rating factors and definitions used, including the area factors, age factors, gender factors, etc., and provide support for the use of each of these factors in the new rate filing. The same level of support for changes to any of these factors must be included in all renewal rate filings. In addition, the commissioner expects each carrier to review each of these rating factors every five (5) years, at minimum, and provide detailed support for the continued use of each of these factors in a rate filing. Gender factors shall not vary for individual health care.

- K. Trend: The memorandum must describe the trend factor assumptions used in pricing. These trend factor assumptions must each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and

adequately supported. Trend factors do not renew automatically. Continued use of trend factors must be supported annually. This must be provided in an Excel spreadsheet.

1. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be provided if available. This experience may include data from the plan being rated, or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.
2. Provided loss data must be on an incurred basis, with pharmacy data shown separately from medical data, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and incurred but not reported (IBNR) reserves) as of the valuation date. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.
3. The provided claims experience shall include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims; total medical incurred claims (including estimated IBNR claims); actual pharmacy paid on incurred claims; total pharmacy incurred claims (including estimated IBNR claims); average covered lives for medical; and, average covered lives for pharmacy.
4. Data elements shall be aggregated into 12-month annual periods, with yearly "per member, per month" (PMPM) data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified. The trend assumptions shall be quantified into two categories, medical and insurance, as defined below:
  - a. Medical trend [(1A) – (1F) in chart below] means, for the purposes of this section, the combined effect of medical provider price increases, utilization changes, medical cost shifting, new medical procedures and technology, and other insurance trend.
  - b. Other insurance trend [(1E) in the chart below] means, for the purposes of this section, the combined effect of any other items impacting medical trend that are not captured in items (1A) through (1D), including the effect of deductible leveraging, anti-selection resulting from rate increases and discontinuance of new sales, and the impact on trend due to anticipated demographic changes. The components of the medical trend noted as (1A) through (1D) in the chart below must be determined or assumed before determining the impacts of the other insurance trend items included in (1E), which must be fully justified in the rate filing.
  - c. Pharmaceutical trend [(2A) – (2F) in the chart below] means, for the purposes of this section, the combined effect of pharmaceutical price increases, pharmacy utilization changes, cost shifting, introduction of new drugs, and other pharmaceutical trend.
  - d. Other pharmaceutical trend, found at (2E) in the cart below, means, for the purposes of this section, the combined effect of any other items impacting pharmaceutical rates that are not captured in items (2A) through (2D), including the effect of pharmaceutical deductible leveraging.

<b>K. TREND</b>	
<b>MEDICAL TREND</b>	<b>TREND (%)</b>

(1A) Medical provider price increase	
(1B) Utilization changes	
(1C) Medical cost shifting	
(1D) Medical procedures and new technology	
(1E) Other Insurance Trend	
(1F) Medical Trend Total Product of (1A) – (1E)	
<b>PHARMACEUTICAL TREND</b>	
(2A) Price increases	
(2B) Utilization changes	
(2C) Cost shifting	
(2D) Introduction of new brand and generic drugs	
(2E) Other Pharmaceutical Trend	
(2F) Pharmaceutical Trend Total Product of (2A) – (2E)	
<b>TOTAL AVERAGE ANNUALIZED TREND (1F) and (2F) weighted proportionately by the mix of carrier's business</b>	

- L. Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three (3) years if the proposed rates are based on claims experience. Partial credibility shall be based on either the number of Life Years OR the number of Claims over a three (3) year period. Partial credibility must be used if the Colorado data is not fully credible. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard). This must be provided in an Excel spreadsheet.
1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially-credible Colorado data, including published data sources (including affiliated companies), must be provided and the use of such data must be justified.
  2. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is the square root of (# life years or claims/full credibility standard). The full credibility standard is defined above, and Colorado data must be provided.
  3. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data should include a discussion as to how the rating methodology was modified for the partially credible data.

L. CREDIBILITY	
<b>1. Credibility Percentage (Colorado Only):</b> If other, please specify	%
The above credibility percentage is based upon:	<input type="checkbox"/> Life Years <input type="checkbox"/> Claims <input type="checkbox"/> Other (please specify)
<b>2. Number of years of data used to calculate above credibility percentage:</b>	

<b>3. Discuss how and if aggregated data meets the Colorado credibility requirement and how the rating methodology was modified for the partially credible data, if applicable.</b>	
<b>Additional Information: (including collateral data, if used)</b>	

- M. Data Requirements: The memorandum must include, at a minimum, earned premium data, loss experience data, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. This must be provided in an Excel spreadsheet.
1. Pharmacy claims data should be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.
  2. National or other relevant data shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.
  3. If the purpose of the filing is to introduce a new product to Colorado, nationwide experience for this product must be provided. If no experience from the new product is available, experience from a comparable product must be provided, including experience data from other carriers that have been used to support the rates.
  4. Support for new policy forms must be provided. If the new policy form is based on an existing policy form, the existing policy form experience will be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a "new product," as defined in this regulation.
  5. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used to support rates must be included in the filing. For both renewal filings and new business filings, the experience period must include consecutive data no older than six (6) months prior to the filing (submission) date.
  6. The loss data must be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Premiums, and/or exposure data, must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information on how the number of claims was calculated.

**M. DATA REQUIREMENTS (Provide separate tables labeled "Pharmacy" and "Medical")**

Colorado-only basis for at least 3 years. <b>Include</b> national, regional or other appropriate basis, if the Colorado data is not fully credible. The experience period must include consecutive data no older than 6 months prior to the filing date.								
<b>COLORADO DATA</b>								
<b>Year*</b>	<b>Earned Premium</b>	<b>Incurred Claims</b>	<b>Estimated IBNR Claims</b>	<b>Total Estimated Incurred Claims</b>	<b>Loss Ratio</b>	<b>Average Covered Lives</b>	<b>Number of Claims</b>	<b>Colorado On Rate Level Premium</b>
20XX								
20XX								
20XX								
20XX								
*This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY								
<b>Above data is for:</b>	<input type="checkbox"/> Existing Product <input type="checkbox"/> Comparable Product <input type="checkbox"/> Other _____ (please specify)							
<b>EXPERIENCE PERIOD</b>								
<b>Date</b>		<b>Earned Premium</b>	<b>Incurred Claims</b>	<b>Estimated IBNR Claims</b>	<b>Total Estimated Incurred Claims</b>	<b>Loss Ratio</b>	<b>Paid Through Date</b>	
<b>From</b>	<b>To</b>							
<b>Blocks of Business Included in experience:</b>								
<b>OTHER DATA</b>								
<b>Year</b>	<b>Earned Premium</b>	<b>Incurred Claims</b>	<b>Estimated IBNR Claims</b>	<b>Total Estimated Incurred Claims</b>	<b>Loss Ratio</b>	<b>Average Covered Lives</b>	<b>Number of Claims</b>	
20XX								
20XX								
20XX								
20XX								
<b>Above data is for:</b>	<input type="checkbox"/> Existing Product <input type="checkbox"/> Comparable Product <input type="checkbox"/> National <input type="checkbox"/> Other (please specify) (Check all the apply)							
<b>Experience Period:</b>	<b>From</b> _____ <b>to</b> _____							
<b>Additional Information:</b>								

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

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

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

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

- P. Rating Manuals: A rating manual must be submitted to the Division for each new product. All changes to the rating manual must be filed with the Division in an appropriate rate filing. Rate pages and rate manual must be attached to the Rate tab in SERFF.
- Q. Actuarial Certification: An actuarial certification must be submitted with all filings. Actuarial Certification is a signed and dated statement made by a qualified Actuary which attests that, in the Actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

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

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



- a. The EHB claims experience of all enrollees in all NGF health benefit plans in a risk pool;
  - b. Adjusted for risk adjustment/reinsurance payments and charges, and Exchange user fees;
  - c. Index rates may be developed separately for supplemental stand-alone benefits, as all such similar benefits are pooled for setting the respective index rate; and
  - d. The premium rate charged during a rating period shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this section.
2. Benefit Design Adjustment: The index rate may be adjusted to reflect differences attributable to different benefit designs. Differences in the rates for different benefit plans, for persons with the same case characteristics of age, geographic location and family size, shall be attributable to benefit design only. Using this methodology, a carrier's rates for a plan with richer benefits should be higher than the rates for a plan with lesser benefits.
3. Acceptable Case Characteristic Factor Categories:
- a. Carriers will be allowed to adjust premiums only for the following factors: self-only or family enrollment, geographic area, age and tobacco. These factors apply to products offered both inside and outside the Exchange, and for both individual and small group products.
  - b. Rates may vary based on whether a plan covers an individual or a family. PHS Act section 2701(a)(4) provides that, with respect to family coverage, the rating variation permitted for age and tobacco use must be applied based on the portion of the premium attributable to each family member covered under a plan.
  - c. The per-member rating methodology under 45 CFR § 147.102(c)(1) must apply. Per-member rating requires that the age and tobacco use factors be apportioned to each family member, and no more than three (3) covered children under the age of 21 whose per-member rates can be taken into account in determining the family premium.
  - d. Geographic area rating factors must not vary by product; there is only one set of area factors for each rate filing. Geographic area rating factors are separate from network factor rating adjustments, and may not vary by network.

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

<u>Geographic Area</u>	<u>Rating Factor</u>
Boulder MSA	0.89
Denver MSA	1.03
Greeley MSA	0.98
Colorado Springs MSA	1.02
Fort Collins MSA	1.01
Grand Junction MSA	0.95
Pueblo MSA	1.05
East Non-MSA	1.27
West Non-MSA	0.99

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

Geographic Location: If a carrier uses geographic location to calculate rates, then it shall use the nine (9) mandatory categories in the following table.

<b>Rating Area</b>	<b>County</b>
Rating Area 1	Boulder
Rating Area 2	El Paso, Teller
Rating Area 3	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
Rating Area 4	Larimer
Rating Area 5	Mesa
Rating Area 6	Weld
Rating Area 7	Pueblo
Rating Area 8 (East)	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Yuma
Rating Area 9 (West)	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit

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

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

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

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

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

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

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and Older	3.000

f. Tobacco Use Rate.

- (1) Carriers may vary tobacco rating by age (for example, a younger enrollee may be charged a lower tobacco use rate than an older enrollee) provided the tobacco use rate does not exceed the non-tobacco use rate contained in § 10-16-107(5)(a)(I)(D), C.R.S.
- (2) Carriers in the individual and small group market may remove the tobacco rating factor (as described in section 2705 of the PHS Act) for individuals participating in a wellness program.
- (3) "Tobacco use" is defined at 45 CFR § 147.102(a)(1)(iv) as the use of a tobacco product or products four (4) or more times per week within, but no longer than, the past six (6) months by legal users of tobacco products (generally those 18 years and older). It includes all tobacco products and clarifies that the term tobacco use does not include religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives). Tobacco use must be defined by carriers in terms of the time since the individual's last use of a tobacco product.

g. Family Size Categories:

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

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

4. Additional Premium Adjustments: Small employer groups may be subject to premium adjustment of no more than 35% above the modified community rate, for a period of no more than twelve (12) months, in certain instances. (See § 10-16-105.6, subsections (3) and (4), C.R.S.) Adequate and acceptably detailed information as to how the carrier determines the rating factor(s) for this adjustment must be included in each rate filing.
5. Wellness and Prevention Programs: A small employer carrier may make wellness and prevention programs available as provided for under Section 7.B. of Colorado Insurance Regulation 4-2-11.

**B. Rating Period**

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

**C. Administrative and Other Fees**

Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Reasonable late payment penalties may be imposed by a small group carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

**D. Calculating Actuarial Value**

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

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

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

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

- Bronze = 60% AV
- Silver = 70% AV
- Gold = 80% AV
- Platinum = 90% AV

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

E. Calculating the Actuarial Value of Unique Plan Designs

1. To satisfy actuarial value (AV) requirements, carriers are required to use the Actuarial Value Calculator (AVC) developed and made available by the United States Department of Health and Human Services unless the plan design is not compatible with the AVC (a unique plan design). In order to assist with this calculation, the SERFF Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. In addition, upon submission of a QHP application, HHS recalculates this value to validate that a carrier's plan designs meet AV requirements.
2. The AVC will be integrated with SERFF so that the Division can evaluate plans for compliance with AV standards on an automated basis. Carriers will first complete the Plans and Benefits Template and submit the information through SERFF; the Plans and Benefits Template will directly populate the AVC to determine a plan's AV and corresponding metal tier. A plan's results from the AVC will be displayed automatically in SERFF.
3. For standard plan designs, carriers will determine AV using an HHS-developed AV calculator. The AVC will guarantee plans with the same cost sharing structure will have the same actuarial value (regardless of plan discounts or utilization estimates).
4. If a carrier determines that a material aspect of its plan design cannot be accommodated by the AVC, HHS allows for alternative calculation methods supported by certification by an actuary.

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

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

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

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

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

2. To account for plan designs that are incompatible and ensure that requiring the use of the AVC allows for plan innovation, 45 C.F.R. § 156.135(b) provides two alternative methods of calculating AV for plans that cannot meaningfully fit within the parameters of the AVC. Carriers issuing such plans must:
  - a. Make adjustments to certain key plan design features to enter a modified plan design that fits into the parameters of the AVC, and have an actuary certify that the plan design was appropriately fit into the parameters of the AVC; or
  - b. Use the AVC to determine the AV for plan provisions that do fit within its parameters, and then have an actuary calculate appropriate adjustments to the Calculator-generated AV to account for remaining plan features. For example, a carrier with reference pricing for prescription drugs could use the AVC to determine the AV for the medical benefits in its plan and then make adjustments to reflect its prescription drug benefits.

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

3. Family Plan Design

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

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

- G. Unique Plan Design

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

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

**H. Determining Minimum Value (MV)**

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

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

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

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

**I. Cost Sharing Limitations**

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

**J. Market Wide Index Rate**

1. The market's risk pool index rate will be used to set the rates for all products of the carrier in that particular market. A carrier will then make a market-wide adjustment to the index rate based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in Colorado. A market-wide adjustment to the index rate will be made for Exchange user fees.
2. Market-wide index rate (average rate) shall be:
  - a. Based on EHB claims experience of all enrollees in all NGF health benefit plans in the risk pool;
  - b. Adjusted for risk adjustment/reinsurance payments and charges, and Exchange user fees; and
  - c. Index rates may be developed separately for supplemental stand-alone benefits, and all such similar benefits are pooled for setting the respective index rate.
3. Rates on an individual policy issued on or after January 1, 2015, are only guaranteed through Dec 31 of that year. All members will receive new rates on January 1 of the following year. For example, an individual enrolling on October 1, 2016 would have their rates in effect until December 31, 2016, and would then be subject to the new rates implemented on January 1, 2017.

**K. Market Wide Index Rate Development**

1. Average Projected Benefit Cost Per-Member-Per-Month
  - a. The index rate will initially be set by determining the average benefit cost of all NGF members in the pool in the state. Carriers are expected to consider all of the usual data adjustments and methods in developing the per-member-per-month (PMPM) cost, from their experience, including the following:
  - b. Credibility: Carriers should determine the credibility levels of experience being used and adjust appropriately. Carriers shall always discuss actuarial justification for credibility of the data being used.
  - c. Typical methods to deal with experience deemed to be less than 100% credible would be:
    - (1) Supplement the Colorado experience with similar national business,
    - (2) Supplement small employer business with other Colorado experience with similar characteristics (membership, network, plan designs).
2. Carriers shall always discuss the impact of large claims on their business; apply methods for adjusting data by pooling large claims above a threshold and apply pooling charges. This consideration is separate from the Transitional Federal Reinsurance program impacts for individual plans in years 2014 through 2016.
3. Carriers must support and provide estimates for the IBNR claims portion of total incurred claims.
4. In developing the health cost trend, costs should be projected to the applicable rating period, assuming an actuarially justifiable health cost trend. For individual business index rates may not be trended monthly or quarterly through any rating period, and index rates must be the same for each month during a rating period. For small employer business, index rates may increase quarterly to reflect trend.
5. Adjustments for Demographic Mix, Benefit Mix, and Area: Other projected population changes from the experience period to the rating period should include considerations of newly uninsureds entering the market, grandfathered members moving into NGF products, and members moving from high-risk pools into commercial plans.
6. Adjustments for underwriting wear-off should be made due to members who were previously underwritten.

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

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



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

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

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

- N. Plan Level Rating Adjustment

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

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

- O. Benefit Factor Adjustments to the Index Rate

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

**P. Retention Factor Adjustments to the Index Rate**

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

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

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

**Q. Network Factor Adjustments**

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

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

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

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

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

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

- R. For the purposes of determining whether a carrier is meeting the federal MLR requirements, a carrier shall provide a list of other plans under its legal entity that will be pooled with the plan in the rate filing for purposes of determining whether the Federal minimum MLR will be met.
1. The carrier is required to provide the estimate of the MLR for the current calendar year and the following calendar year. The carrier is requested to indicate all adjustments allowed in the minimum MLR calculation that will be used to reach the minimum required MLR. Federal minimum MLR requirements are as follows:
    - a. Large Group: 85%
    - b. Small Group: 80%
    - c. Individual: 80%, includes Student Health Plans
  2. Allowable MLR adjustments from Colorado's benefit ratio are as follows:
    - a. Tax: State and federal taxes may be subtracted from earned premium in the denominator;
    - b. L&R: Licensing and regulatory fees may be subtracted from earned premium in the denominator;
    - c. QI: Quality Improvement costs may be added to the numerator;
    - d. ICD: ICD-10 implementation costs up to 0.3% of premium may be added to the numerator;
    - e. Cred: Credibility adjustment percent based on the plan's size is added to the Base Loss Ratio; and
    - f. Ded: Deductible adjustments based on average deductible, applied as a multiple to Cred.

**S. Essential Health Benefits (EHBs)**

1. Carriers are to provide EHBs and essential health care benefit packages.
2. Essential benefits include providing prescription drug coverage that covers at least the greater of:
  - a. One drug in every United States Pharmacopeial Convention (USP) Model category and class; or
  - b. The same number of prescription drugs in each category and class as the EHB benchmark plan. A drug is considered covered if the health benefit plan pays for all or part of the drug regardless of tiers and cost sharing. The specific drugs covered on each carrier's formulary may vary as long as the minimum number in each category and class is met.

**T. Stand-alone Dental (SADP)**

1. QHPs in an Exchange may omit the pediatric dental EHB if a SADP in the Exchange offers pediatric dental EHB coverage.
2. SADPs are allowed a separate out-of-pocket maximum
  - a. SADPs are required to demonstrate that the out-of-pocket maximum is reasonable for pediatric dental EHB.
  - b. The Division will make the final determination as to what constitutes a reasonable out-of-pocket maximum for pediatric dental EHB.
  - c. The cost sharing annual limit for a pediatric dental plan will be at or below \$350 for a plan with a single child enrollee, or \$700 for a plan with two or more child enrollees is considered reasonable and no higher limit will be approved.
3. SADPs are not required to use the AVC, but will have a low and/or high plan (70% AV and 85% AV, respectively).
4. Pediatric dental plans provide coverage up to age 19.
5. The standardized rating regions that apply to the medical QHPs do not apply to SADP. Each dental carrier can determine its area adjustment factors and how to vary such factors by geographic locations. If zip codes are used to establish the area adjustment factors, no zip code smaller than a three (3) digit zip code may be used when establishing an area.
6. The standard rating tiers and child factors applicable to the medical QHP do not apply to SADP. The dental carrier can develop a rating structure that conforms to federal and state laws.
7. The pediatric dental EHB offered by a stand-alone dental plan must be offered without annual and lifetime limits. Such limits may be used for benefits offered in addition to pediatric dental essential health benefits as well as for adult dental benefits.

**U. Student Plans**

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

**Section 8 Rate Filings and Actuarial Certification**

- A. The provisions of § 10-16-107, C.R.S. and this regulation shall apply to the filing of rates for individual, small and large group health benefit plans. Expected rate increases for individual, small and large group health benefit plans shall be submitted for approval to the Division of Insurance at least sixty (60) days prior to the proposed rate implementation and/or effective date.
- B. Small group health benefit plan rate filings shall not be combined with either individual or large group health benefit rate filings. Additionally, they shall be filed separately by type of coverage (indemnity, preferred provider organization, or health maintenance organization).
- C. Individual health benefit plan rates shall be filed no more frequently than annually. Small group health benefit plan rates shall be filed annually, with an effective date of January 1.
  1. Small group health benefit plan filings may include quarterly trend increases. As of October 1, 2014, small group health benefit plan rates may be filed no more frequently than quarterly.
  2. Annual filings for rates effective on January 1 must be submitted no later than May 15 of the previous year. For example, for rates to be effective on January 1, 2017, rates must be filed no later than May 15, 2016.
- D. Stand-alone dental plans offering the pediatric dental coverage mandated by PPACA as EHBs, must be “Exchange certified stand-alone dental plans”. The “Product Name” on the General Information tab in SERFF must identify the filings as “PPACA Dental.” New filings must be submitted in accordance with the PPACA rate filing requirements for Colorado.

**Section 9 Additional Requirements for Large Group Health Benefit Plans**

- A. Large Group Health Coverage Plans: Large group health coverage plan contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing must contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing should contain an example of how the large group health rates are calculated. While the final rate charged the large group may differ from the initial quote, all rating variables must be on file with the Division.

Although it is not necessary to submit a separate rate filing for each large group policy issued, each carrier must retain detailed records for each large group policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each group insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate should be identified in the detail material and lie within the range identified in the rate filing on file with the Division. The carrier shall make all such information available for review by the commissioner upon request. All such requests will be made at least three (3) business days prior to the date of review.

The rates for subgroups must be determined in an actuarially sound manner using credible data. The methodology for determining these rates must be on file with the Division and any changes in the methodology must be filed with the Division.

- B. Valid Multi-State Association Groups: Valid multi-state associations shall not use any health status-related factor in determining the premium or contribution for any enrolled individual and/or their dependent. However, the prohibition in this subsection shall not be construed to prevent the carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for adherence to programs of health promotion or disease prevention if otherwise allowed by state or federal law.
- C. Determining Minimum Value
1. A group health plan provides minimum value (MV) if the total allowed costs of benefits paid by the plan is no less than 60%.
  2. An individual eligible for coverage in an employer-sponsored plan that provides MV is not eligible for premium tax credits.
  3. A group health plan may determine if it provides MV using the following methods:
    - a. The Minimum Value Calculator; or
    - b. A safe harbor established by HHS and IRS; or
    - c. Certification by an actuary if neither is suitable.
- D. Network Factor Adjustments

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

1. Differences in reimbursement levels and discounts between providers;
2. Differences in the utilization management of members, including tighter control of referrals, stricter managed care, disease management and wellness programs, etc.; and
3. Other delivery system characteristics of a network.

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**Section 10      Prohibited Rating Practices**

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

- A.      Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating;
- B.      The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income;
- C.      Pursuant to § 10-16-107(2)(b), C.R.S, individual health benefit plans rates shall not vary due to the gender of the individual policyholder, enrollee, subscriber, or member.
- D.      For large group health benefit plans, the use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss. It is the expectation of the commissioner that areas of the state with like expectations of loss must be treated in a similar manner. Also, policyholders utilizing the same provider groups should be rated in a like manner. The use of zip codes in determining rating factors can result in inequities. Unless different rating factors can be justified based upon different provider groups or other actuarially sound reasons, the following guidelines shall be followed whenever zip codes are used in determining a carrier's rating factors:
  - 1.      All zip codes in the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor, with the following possible exceptions:
    - a.      The following zip codes in Elbert County: 80101, 80106, 80107, 80117;
    - b.      The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136;
    - c.      The following zip codes in El Paso County: 80132, 80133;
    - d.      The following zip codes in Boulder County: 80025, 80026, 80027, 80028.
  - 2.      In addition, the following zip codes outside the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor as the 800-802 three-digit zip code groups:
    - a.      The following zip codes in Jefferson County: 80401-80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465; and
    - b.      The following zip codes in Adams County: 80614, 80640.
  - 3.      All zip codes in the 809 three-digit zip code group are considered part of the Colorado Springs metropolitan area and shall receive the same rating factor. In addition, the following zip codes in El Paso County, which lie outside the 809 three-digit zip code group shall be considered part of the Colorado Springs metropolitan area and shall receive the same rating factor as the 809 three-digit zip code group: 80809, 80817, 80819, 80829, 80831, 80840, 80841.

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

**Section 11      Use of Composite Rates in the Small Group Market**

- A. Small group carriers may offer small group rates calculated using a four-tier family rate and, in addition or in the alternative, may offer small groups individual rates calculated for each employee pursuant to Section 7. of this regulation. If a small group carrier offers composite rating, the carrier must offer the small group the choice of both individually rated employees and composite rates, at initial application and each renewal.
- B. If a small group carrier offers both rating methodologies for a plan, the small group carrier must ensure that:
  - 1. Both methods are offered to every small group, with differences between methodologies clearly explained in writing: or
  - 2. Every small group must be given a written option to indicate in check-off form, or other similar form, in the application or renewal application, that:
    - a. Both rating methods need to be presented;
    - b. Only rates for individual employees need to be presented; or
    - c. Only the composite rate needs to be presented.
- C. Small group carriers may offer small groups four-tier composite rates as an alternative to rates calculated individually for each employee pursuant to Section 7. of this regulation. If the small group carrier offers composite rating, the carrier must make the same offer for all plans, except as allowed by paragraph H of this section 10.
- D. Calculating Composite Rates
  - 1. The total premium charged to the small group must be calculated using the per-member methodology in Section 7. of this regulation. Age, geographic area and tobacco use (if applicable) are determined at the time coverage is issued to the group. The small group's total premium is equal to the sum of the premiums for each covered employee and his/her covered spouse and/or dependents.
  - 2. Once the small group's total premium has been calculated, it must be allocated to covered employees based on the tier factor applicable to each employee's family composition. All carriers will use the following standard tier definitions and factors:
    - a. Employee Only = 1.00
    - b. Employee and Spouse = 2.00
    - c. Employee and Child(ren) = 1.85
    - d. Employee, Spouse, and Child(ren) = 2.85



3. Any allowable tobacco use factor must be allocated separately to the corresponding individual employee or dependent, so the average Employee Only premium does not include any tobacco factor.
- E. A small group's total composite premium must equal the sum of the per-member premiums for all covered employees and dependents. In addition, once the composite premiums are computed at the beginning of the plan year, they must not vary during the plan year, regardless of any census changes within the group.
- F. If the small group carrier offers composite rating, the Colorado alternative tiered-composite premium methodology will be required to be offered to all small groups without regard to size, except as allowed by paragraph H of this section 10.
- G. Small group carriers may decide which plans will offer composite premium and which plans will not.
- H. Small group carriers offering plans on the Small Employer Health Options Program are not required to include the option of composite rating for those small group plans offered on the Small Employer Health Options Program, unless and until Connect for Health Colorado implements the ability for small group carriers to utilize composite rating in the Small Employer Health Options Program.

## **Section 12      Incorporated Materials**

Colorado Insurance Regulation 4-2-11, 3 CCR 702-4 published by the Colorado Division of Insurance shall mean Colorado Insurance Regulation 4-2-11, 3 CCR 702-4 as published on the effective date of this regulation and does not include later amendments to or editions of Colorado Insurance Regulation 4-2-11, 3 CCR 702-4. Colorado Insurance Regulation 13-E-01, 3 CCR 702-4 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Colorado Division of Insurance Website at [www.dora.colorado.gov/insurance/](http://www.dora.colorado.gov/insurance/). Certified copies of Colorado Insurance Regulation 4-2-11, 3 CCR 702-4 are available from the Division of Insurance for a fee.

45 CFR § 147.102 published by the Government Printing Office shall mean 45 CFR § 147.102 as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 147.102. A copy of the 45 CFR § 147.102 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the 45 CFR § 147.102 may be requested from the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at [www.ecfr.gov](http://www.ecfr.gov).

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

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

### **Section 13 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 14 Enforcement**

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

### **Section 15 Effective Date**

This regulation shall become effective on January 1, 2016.

### **Section 16 History**

Regulation effective October 1, 2013.

Amended regulation effective April 15, 2014.

Amended regulation effective August 15, 2014.

Amended regulation effective January 1, 2016.

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

- A. Format: All required reports and documentation must be submitted through SERFF in a searchable PDF format. All tables identified in Section 6 of this regulation must also be submitted in an Excel format (in addition to the searchable PDF).
- B. Submission Requirements for New Rate Filings: Carriers must complete and submit the following information in SERFF in order for a rate filing submission to be considered complete:
  - 1. Carriers must complete all SERFF required data fields.
  - 2. Carriers must list all forms associated with the rate filing under the Form Schedule Tab.
    - a. Carriers must complete all data fields (Form Name, Form Number, Form Type, Action, Readability Score) under this tab.
    - b. Carriers are not required to attach copies of the actual form documents as part of a rate filing.
  - 3. Carriers must attach a copy of the Rate Tables/Manual under the Rate/Rule Schedule Tab.

4. Carriers must attach copies of the following documents under the Supporting Documentation Tab in the Filing (Non-Binder) section in SERFF:
  - a. If a carrier uses a third party to submit a form filing on their behalf, a Letter of Authority, which must be attached under the Supporting Documentation Tab in SERFF.
  - b. A copy of the Colorado Actuarial Memorandum, which includes all elements contained in Section \_\_\_ of this regulation.
  - c. The following documents required by the Centers for Medicare and Medicaid Services:
    - i. Part I – Unified Rate Review Template;
    - ii. Part II – Consumer Justification Narrative must be completed for all rate increases, but is optional for new plans;
    - iii. Part III – Actuarial Memorandum.
  - d. Any applicable justification or attestations forms specified by the Division.
5. Carriers must complete and upload the following templates, under the Template Tab in the Plan Management (Binder) section of SERFF:
  - a. Business Rules Template;
  - b. Plans and Benefits Template;
  - c. Prescription Drug Template;
  - d. Network Template;
  - e. Rate Data Template; and
  - d. Service Area Template.
6. Carriers must attach copies of the following documents required by the Centers for Medicare and Medicaid Services under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF
  - a. Part I - the Unified Rate Review Template; and
  - b. Part II - Consumer Justification Narrative, which must be completed for all rate increases, but optional for new plans.

## **APPENDIX B – Sample Rate Table**

### 201X Individual Market Rate Table

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

Age	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
<20	196.37	200.30	192.45	197.36	189.50	191.47	203.25	197.36	185.57
21	309.26	315.45	303.08	310.81	298.44	301.53	320.09	310.81	292.25
22	309.26	315.45	303.08	310.81	298.44	301.53	320.09	310.81	292.25
23	309.26	315.45	303.08	310.81	298.44	301.53	320.09	310.81	292.25
24	309.26	315.45	303.08	310.81	298.44	301.53	320.09	310.81	292.25
25	310.50	316.71	304.29	312.05	299.63	302.74	321.37	312.05	293.42
26	316.68	323.02	310.35	318.27	305.60	308.77	327.77	318.27	299.26
27	324.10	330.58	317.62	325.72	312.76	316.00	335.45	325.72	306.28
28	336.17	342.89	329.44	337.85	324.40	327.76	347.93	337.85	317.68
29	346.06	352.98	339.14	347.79	333.94	337.41	358.17	347.79	327.02
30	351.01	358.03	343.99	352.76	338.72	342.23	363.29	352.76	331.70
31	358.44	365.60	351.27	360.23	345.89	349.47	370.98	360.23	338.72
32	365.85	373.17	358.54	367.68	353.05	356.71	378.66	367.68	345.73
33	370.49	377.90	363.08	372.34	357.52	361.23	383.46	372.34	350.11
34	375.44	382.95	367.93	377.32	362.30	366.05	388.58	377.32	354.79
35	377.91	385.47	370.35	379.80	364.68	368.46	391.14	379.80	357.12
36	380.39	388.00	372.78	382.29	367.08	370.88	393.70	382.29	359.47
37	382.86	390.52	375.20	384.77	369.46	373.29	396.26	384.77	361.80
38	385.34	393.05	377.63	387.27	371.85	375.71	398.83	387.27	364.15
39	390.29	398.09	382.48	392.24	376.63	380.53	403.95	392.24	368.82
40	395.23	403.13	387.32	397.20	381.40	385.35	409.06	397.20	373.49
41	402.66	410.71	394.60	404.67	388.56	392.59	416.75	404.67	380.51
42	409.76	417.96	401.57	411.81	395.42	399.52	424.11	411.81	387.23
43	419.66	428.06	411.27	421.76	404.97	409.17	434.35	421.76	396.58
44	432.03	440.67	423.39	434.19	416.91	421.23	447.15	434.19	408.27
45	446.57	455.50	437.64	448.80	430.94	435.40	462.20	448.80	422.01
46	463.89	473.16	454.61	466.20	447.65	452.29	480.12	466.20	438.37
47	483.37	493.04	473.70	485.79	466.45	471.29	500.29	485.79	456.78
48	505.64	515.75	495.52	508.17	487.94	493.00	523.33	508.17	477.83
49	527.59	538.14	517.04	530.23	509.13	514.40	546.06	530.23	498.57
50	552.36	563.39	541.29	555.10	533.01	538.53	571.67	555.10	521.96
51	576.76	588.30	565.23	579.65	556.58	562.34	596.95	579.65	545.04
52	603.67	615.74	591.59	606.69	582.54	588.58	624.80	606.69	570.47
53	630.89	643.50	618.27	634.04	608.80	615.11	652.97	634.04	596.19
54	660.27	673.47	647.06	663.57	637.16	643.76	683.38	663.57	623.95
55	689.64	703.44	675.85	693.09	665.51	672.40	713.78	693.09	651.71
56	721.50	735.93	707.07	725.10	696.24	703.46	746.75	725.10	681.81
57	753.66	768.74	738.59	757.43	727.29	734.82	780.04	757.43	712.21
58	787.99	803.75	772.23	791.93	760.41	768.29	815.57	791.93	744.65
59	805.00	821.10	788.90	809.03	776.83	784.88	833.18	809.03	760.73
60	839.33	856.11	822.54	843.52	809.95	818.34	868.70	843.52	793.16
61	869.01	886.39	851.63	873.36	838.60	847.29	899.43	873.36	821.22
62	888.50	906.27	870.73	892.94	857.40	866.28	919.59	892.94	839.63
63	912.93	931.19	894.67	917.50	880.98	890.11	944.88	917.50	862.72
64+	927.79	946.34	909.23	932.43	895.32	904.59	960.26	932.43	876.76

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

**Regulation 4-2-40      CONCERNING THE ELEMENTS OF CERTIFICATION FOR CERTAIN LIMITED BENEFIT PLANS, CREDIT LIFE AND HEALTH, PRENEED FUNERAL CONTRACTS, EXCESS LOSS INSURANCE FORMS, AND SICKNESS AND ACCIDENT INSURANCE, OTHER THAN HEALTH BENEFIT PLANS**

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

**Section 1      Authority**

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

**Section 2      Scope and Purpose**

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

**Section 3      Applicability**

This regulation applies to all insurers and other entities authorized to conduct business in Colorado who are required to fully execute and file a certification form and complete the Form Schedule Tab in the System for Electronic Rate and Form Filings (SERFF). This includes insurers and other entities who provide sickness and accident insurance, credit disability, credit - FMLA, credit - life, accident only, specified disease, intensive care, organ & tissue transplant, dental, disability income, and short term care. This also includes insurers and other entities who provide hospital indemnity, travel, vision, long-term care, pre-need funeral contracts, accidental death and dismemberment, hospital/surgical/medical, prescription drug, and excess loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act" (ERISA). This regulation does not change the certification requirements for pre-need funeral contract sellers who utilize Colorado's prototype pre-need funeral contracts. This rule does not apply to health benefit plans. This rule replaces Emergency Regulation 13-E-05 in its entirety.

**Section 4      Definitions**

- A. "Accident only" means, for the purposes of this regulation, coverage for death, dismemberment, disability, or hospital and medical care caused by or necessitated as the result of accident or specified kinds of accident. "Accident only" policies cannot include 'sickness' or 'wellness' benefits. If additional benefits are provided they must be fully disclosed and properly labeled.
- B. "Annual Report for credit insurance" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.K. of this regulation.

- C. "Annual Report for health coverage plans" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.L. of this regulation.
- D. "Annual Report for preneed contracts" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.M. of this regulation.
- E. "Certification of compliance" means, for the purposes of this regulation, the form that contains the necessary elements of certification, as determined by the commissioner, which has been signed by the designated officer of the insurer.
- F. "Certification of compliance for excess loss insurance" means, for the purposes of this regulation, a certification form, which contains the elements of certification as determined by the commissioner, signed by a designated officer of the insurer, and used in conjunction with self-insured employer benefit plans under ERISA.
- G. "Credit Insurance" for the purposes of this regulation, shall have the same meaning as defined in § 10-10-103(2), C.R.S.
- H. "Disability Income policy" means, for the purposes of this regulation, a policy that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury. "Disability income policies" cannot include annual doctor visits or outpatient coverage. Short-term disability coverages may be filed separately from long-term disability income coverages. If additional benefits are provided they must be fully disclosed and properly labeled.
- I. "Entity" means, for the purposes of this regulation, any organization that provides sickness and accident insurance, credit insurance, preneed funeral contracts, or excess loss coverage in this state. For the purpose of this regulation, "entity" includes insurers providing health coverage through fraternal benefit societies, health maintenance organizations, nonprofit hospital and health service corporations, sickness and accident insurance companies, and any other entities providing a plan of health insurance or health benefits subject to the Colorado insurance laws and regulations.
- J. "Excess loss insurance" means, for the purposes of this regulation, the excess loss insurance provided in conjunction with self-insured employer benefit plans under ERISA, and that comply with the requirements set forth in § 10-16-119, C.R.S.
- K. "Health benefit plan" for the purposes of this regulation shall have the same meaning as defined in § 10-16-102(32), C.R.S.
- L. "Health coverage" means, for the purposes of this regulation, services included in furnishing to any individual, medical, mental, dental, optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human physical or mental illness or injury, other than health benefit plans.
- M. "Health coverage plan" for the purposes of this regulation shall have the same meaning as defined in § 10-16-102(34), C.R.S., and shall mean a contract, certificate or agreement entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. For the purposes of this regulation, the term "health coverage plan" does not include health benefit plans.

- N. "Hospital indemnity" means, for the purposes of this regulation, a policy that provides a stated daily, weekly or monthly payment while the insured is "hospitalized" regardless of expenses incurred and regardless of whether or not other insurance is in force. "Hospital indemnity" policies cannot include medical expense, wellness benefits or well-baby care. If additional benefits are provided they must be fully disclosed and properly labeled.
- O. "Listing of New Policy forms for credit insurance" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF, including the documents and information listed in Section 5.N. of this regulation.
- P. "Listing of New Policy Forms for health coverage" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.O. of this regulation.
- Q. "Listing of New Policy Forms for preneed contracts" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.P. of this regulation.
- R. "New Policy Form or Product" means, for the purposes of this regulation, a policy form that has "substantially different new benefits" or unique characteristics associated with risk or cost that are different from existing policy forms. For example: A guaranteed issue policy form is different than an underwritten policy form, a managed care policy form is different than a non-managed care policy form, a direct written policy form is different from a policy sold using producers, etc.
- S. "Officer of an entity" means, for the purposes of this regulation, the president, vice-president, assistant vice-president, corporate secretary, chief executive officer (CEO), chief financial officer (CFO), chief operating officer (COO), assistant corporate secretary, funeral director, general counsel or actuary who is a corporate officer, or any officer appointed by the board of directors.
- T. "Plan" means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.
- U. "Policy of sickness and accident" for the purposes of this regulation shall have the same meaning as defined in § 10-16-102(50), C.R.S.
- V. "Product(s)" means, for the purposes of this regulation, the services covered as a package under a policy form by a carrier, which may have several cost-sharing options and riders as options.
- W. "Program" means, for the purposes of this regulation, the title of an entity's insurance program, product or preneed funeral contract.
- X. "Signature" means for the purposes of this regulation, the original signature of an officer, or an electronic signature as defined in § 24-71.3-102, C.R.S.
- Y. "Specified disease coverage" means, for the purposes of this regulation, payment of benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or principal sum.
- Z. "Substantially different new benefit" means for the purposes of this regulation, a new benefit that results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product does not create a new form.

**Section 5      Rules**

- A.      At least thirty-one (31) days prior to using any new form (except preneed funeral contract and excess loss insurance, which are filed concurrently) each entity, subject to the provisions of this regulation, shall file, in a format prescribed by the commissioner, a fully-executed certificate of compliance form, and complete the Form Schedule Tab in SERFF.
- B.      Preneed funeral contract and excess loss insurance form certifications shall file a fully-executed certification of compliance, and complete the Form Schedule Tab in SERFF, in a format prescribed by the commissioner, prior to, or concurrently with, the use of the form by each entity. For excess loss insurance, the actual forms to be used need to be submitted in the forms schedule tab.
- C.      No later than July 1 of each year, each preneed contract insurer or credit insurer shall file an Annual Report of policy forms including a fully-executed certificate of compliance and complete the Form Schedule Tab in SERFF.
- D.      Not later than December 31 of each year, each entity providing sickness and accident coverages shall file an Annual Report of policy forms, including a fully executed certificate of compliance and complete the Form Schedule Tab in SERFF. However, excess loss insurance, used in conjunction with self-insured employer benefit plans under ERISA does not require the filing of an Annual Report of policy forms.
- E.      Certification requirements.
  - 1.      The elements of certification are as follows:
    - a.      The name of the entity;
    - b.      A statement that the officer signing the certification form is knowledgeable of accident and sickness insurance or health care benefits (other than health benefit plans), preneed funeral contracts, excess loss insurance, or credit insurance, whichever is being certified;
    - c.      A statement that the officer signing the certification form has carefully reviewed the policy forms, subscription certificates, membership certificates, preneed funeral contracts or other evidences of health care coverage identified on the Form Schedule Tab in SERFF, or in the case of excess loss insurance, the actual forms are attached;
    - d.      A statement that the officer signing the certification form has read and understands each applicable law, regulation, and bulletin;
    - e.      A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncomplying form or contract;



- f. A statement that the officer signing the certification form certifies:
  - (1) For Listings of New Policy Forms for health coverage or, in the case of excess loss insurance, the actual forms themselves, that the certifying officer has reviewed, signed and placed on file, and in the case of excess loss insurance, the excess loss for ERISA plan guide, and to the best of the officer's good faith, knowledge and belief, the new policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, provide all applicable mandated coverages and are in full compliance with all Colorado insurance laws and regulations, and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.
  - (2) For Annual Reports of all policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements or riders for any sickness, accident, limited benefit plans and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms identified in the Form Schedule Tab in SERFF, provide all applicable mandated coverages and are in full compliance with all Colorado insurance laws and regulations, and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.
  - (3) For Listings of New Policies for credit insurance, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders, and to the best of the officer's knowledge, each policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider in use complies with Colorado law.
  - (4) For Listings of New Contract Forms and Annual Reports for preneed funeral (§ 10-15-101 et seq., C.R.S.) contracts (prototype contracts are excluded from this requirement), the contract seller must certify that, to the best of the seller's knowledge, each preneed funeral contract or form of assignment is in full compliance with all Colorado insurance laws and regulations;
- g. Annual Reports for health coverage shall contain a statement in the form certification that states: "Copies of the rates and the classification of risks or subscribers pertaining thereto are on file with the commissioner."
- h. The name and title of the officer signing the certification form and the date the certification form is signed;
- i. The original signature of the officer. Signature stamps, photocopies or a signature on behalf of the officer are not acceptable. Electronic signatures must be in compliance with § 24-71.3-102, C.R.S., and applicable regulations.

2. The elements of certification must be included in:
  - a. Form Health (Colorado Health Coverage Certification Form for Listing of New Policy Forms);
  - b. Form Health Annual (Colorado Health Coverage Certification Form for Annual Reports);
  - c. Form CI (Colorado Credit Insurance Policy Certification Form for Annual Reports and Listings of New Policy Forms);
  - d. Form PN (Colorado Preneed Certification Form for Annual Reports and Listings of New Contracts); and
  - e. Form Excess Loss (Colorado Excess Loss Insurance for Self-Insured Employer Benefit Plans under ERISA Certification Form),
- F. If the individual signing the certification is other than the president, vice-president, assistant vice-president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel or an actuary that is also a corporate officer, documentation shall be included that shows that this individual has been appointed as an officer of the organization by the board of directors. This documentation is to be submitted with every filing.
- G. If an insurer or carrier uses the optional method of electronic dissemination of newly issued or renewed policy forms or endorsements, the insurer or carrier must comply with Colorado's Uniform Electronic Transactions Act (UETA) § 24-71.3-101 et seq., C.R.S. UETA guidance is provided by the Colorado Office of Information Technology and the Colorado Division of Insurance.
- H. All filings submitted in the format prescribed by the commissioner, in SERFF, shall have the Form Schedule Tab completed with the form name, form number, edition date, form type, action, action specific data, and readability score where required by law. Only forms related to excess loss policies must be attached.
- I. Rate changes that impact "New Business Only" must be filed as a 'rate change' to an existing product. ANY changes to the rating methodology, rating factors, rates, or assumptions must be identified, and the overall experience data for the existing product must be provided.
- J. Insurers and other entities shall not represent an existing policy form or product to be a new policy form or product, if the policy form or product is not a new policy form or product. If a policy form or product is not a new policy form or product and the rate is increasing, the rate filing is prior approval. If an existing policy form is modified and it is truly not a new policy form it will need to comply with the provisions of § 10-16-105.1(5), C.R.S.
- K. In order to file an "Annual Report for credit insurance" the insurer must complete the Form Schedule Tab in SERFF. The report must include all credit insurance policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders issued or delivered to any policyholder in Colorado. Such listing shall be submitted on or before July 1 of each year. Each annual report shall include a certification by an officer of the organization that, to the best of the officer's knowledge, each policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider in use complies with Colorado law. Attaching the actual forms is not required.

- L. In order to file an "Annual Report for health coverage plans" the insurer must complete the Form Schedule Tab in SERFF. The report must include all health coverage policy forms, application forms (including any health questionnaires used as part of the application process), endorsements or riders for any sickness, accident, and/or health coverage policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms. This annual report shall include a certification that the rates and classification of risks or subscribers pertaining to the policies, endorsements, riders, or applications are on file with the commissioner. Listing the readability score and attaching the actual form(s) is not required.
- M. In order to file an "Annual Report for preneed contracts" the insurer must complete the Form Schedule Tab in SERFF. The report must include all written contracts currently in use, but not limited to, forms of assignment, agreements, or mutual understandings, any series or combination of contracts, agreements, or mutual agreements, or mutual understanding, or any security or other instrument which is convertible into a contract, agreement, or mutual understanding whereby it is agreed that, upon the death of the preneed contract beneficiary, a final resting place, merchandise, or service shall be provided or performed in connection with the final disposition of the preneed contract beneficiary's body. Attaching the actual forms is not required.
- N. In order to file a "Listing of New Policy forms for credit insurance" the insurer must complete the Form Schedule Tab in SERFF. The listing must include all policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery to any policyholder in Colorado with the form name, unique form number for new policies, edition date, form type, action, and action specific data. Attaching the actual forms is not required.
- O. In order to file a "Listing of New Policy Forms for health coverage plans" the insurer must complete the Form Schedule Tab in SERFF. The listing must include any new policy forms, application forms (including any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health coverage policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, with a description of the form, unique form number for new forms, including the edition date for amended forms, the title of the program or product affected by the form, and the readability score where required by law. In order to file New Policy Forms for Excess Loss, actual forms must be attached to the Form Schedule tab in SERFF. Excess loss forms must include description of the form, the unique form number for new forms including the edition date for amended forms, and the title of the program or product affected by the form, and the readability score.
- P. In order to file a "Listing of New Policy Forms for preneed contracts" the insurer must complete the Form Schedule Tab in SERFF. The listing must include all new written contracts, forms of assignment, agreements, or mutual understandings, any series or combination of contracts, agreements, or mutual agreements, or mutual understanding, or any security or other instrument which is convertible into a contract, agreement, or mutual understanding whereby it is agreed that, upon the death of the preneed contract beneficiary, a final resting place, merchandise, or service shall be provided or performed in connection with the final disposition of the preneed contract beneficiary's body. Additionally, the preneed funeral contract seller shall include a description of the form, the unique form number for new forms including the edition date for amended forms, and the title of the program or product affected by the form. All preneed funeral contract sellers shall certify preneed contracts to the commissioner concurrent with the use of such preneed contracts. Attaching the actual forms is not required.
- Q. New plan designs under an existing product or policy form must identify the difference in benefits, and must also state if the benefits have been previously offered under the policy form and then later removed.

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**Section 6      Readability**

- A. Pursuant to § 10-16-107.3, C.R.S., entities writing health coverage plans, limited benefit health insurance, dental plans, or long-term care plans, must include the Flesch-Kincaid grade level or the Flesch Read Ease score in the electronic filing. The Flesch-Kincaid grade level shall not exceed the tenth grade level or the Flesch Read Ease score shall not be less than 50.
- B. Entities may choose either the Flesch-Kincaid grade level formula or the Flesch Read Ease formula to generate a readability score. However, once a formula has been selected from these two (2) formulas, the selected formula shall be used consistently for all text being scored for that particular policy.
- C. All riders, amendments, endorsements, applications, and other forms made a part of the policy by a carrier must either be scored as a separate form, or as part of the policy with which they may be used.
- D. For the purposes of the readability score, amendments, riders, and endorsements that are made part of the policy, evidence of coverage, or certificate of coverage, are required to comply with the readability score. Cancellation notices, renewal notices, disclosure forms, and notices of reductions in coverage do not require a readability score.

**Section 7      Severability**

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

**Section 8      Enforcement**

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

**Section 9      Effective Date**

This regulation shall become effective on October 1, 2013.

**Section 10     History**

Originally issued as Final Regulation 1-1-6 effective June 1, 1994.  
Amended Regulation 1-1-6 effective February 1, 2002.  
Amended Regulation 1-1-6 effective June 1, 2003.  
Sections 1, 2, 3, 8 and 9 amended effective February 1, 2004.  
Amended Regulation effective January 1, 2012.  
Regulation 1-1-6 repealed in full October 1, 2013.  
Regulation effective October 1, 2013.

**Regulation 4-2-41      CONCERNING THE ELEMENTS FOR FORM FILINGS FOR HEALTH BENEFIT PLANS AND CERTAIN DENTAL COVERAGE FORMS AND CONTRACTS**

- Section 1      Authority
- Section 2      Scope and Purpose
- Section 3      Applicability
- Section 4      Definitions
- Section 5      Rules

Section 6	Readability
Section 7	Severability
Section 8	Enforcement
Section 9	Effective Date
Section 10	History
Appendix A	Form Filing Requirements

## **Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-3-1110, 10-16-107.2(3), 10-16-107.3(1)(b), and 10-16-109, C.R.S.

## **Section 2 Scope and Purpose**

The purpose of this regulation is to promulgate rules applicable to the form filing requirements for health benefit plans and stand-alone pediatric dental plans.

## **Section 3 Applicability**

This regulation applies to all carriers marketing and issuing individual, small group, and/or large group health benefit plans, and all carriers marketing and issuing stand-alone dental plans that provide for pediatric dental as an essential health benefit subject to Colorado insurance laws. This regulation excludes certain limited benefit plans, credit life and health policies, preneed funeral contracts, excess loss insurance forms, and sickness and accident insurance other than health benefit plans.

## **Section 4 Definitions**

- A. "Annual Report for Health Coverage Plans" means, for the purpose of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.A.3. of this regulation.
- B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- C. "Certification" means, for the purpose of this regulation, a certification form, which contains elements of certification as determined by the commissioner, signed by a designated officer of the carrier.
- D. "Connect for Health Colorado" shall have the same meaning as "Exchange" as found at § 10-16-102(26), C.R.S.
- E. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.
- F. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.
- G. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- H. "Listing of New Policy Forms for Health Coverage" means, for the purpose of this regulation, completing the Form Schedule Tab in SERFF, including the documents and information listed in Section 5.A.2. of this regulation.
- I. "Officer" means, for the purposes of this regulation, the president, vice-president, assistant vice-president, corporate secretary, chief executive officer (CEO), chief financial officer (CFO), chief operating officer (COO), assistant corporate secretary, funeral director, general counsel or actuary who is a corporate officer, or any officer appointed by the board of directors.

- J. "Pediatric dental plan" means, for the purpose of this regulation, a stand-alone dental plan that provides coverage of the required pediatric dental essential health benefits.
- K. "Plan" means, for the purpose of this regulation, the specific benefits and cost-sharing provisions available to a covered person.
- L. "Product(s)" means, for the purpose of this regulation, the services covered as a package under a policy form by a carrier, which may have several cost-sharing options and riders as options.
- M. "Program" means, for the purpose of this regulation, the title of a carrier's health coverage program or product.
- N. "SERFF" means, for the purpose of this regulation, System for Electronic Rate and Form Filings.
- O. "Signature" includes an electronic signature as found at § 24-71.3-102(8), C.R.S.
- P. "Substantially different new benefit" means, for the purpose of this regulation, a new benefit that, in the minimum, results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product does not create a new form.

## **Section 5      Rules**

All policies, riders, contracts, application forms, endorsements, certificates and other evidence of health coverage associated with health benefit plans and pediatric dental plans must be filed with the Division of Insurance (Division). All form filings shall be submitted electronically by licensed entities. Failure to supply the information required in Section 5 of this regulation will render the filing incomplete.

### **A.      General Requirements**

- 1. For all filings, carriers must complete the Form Schedule Tab in SERFF with the form name, form number, edition date, form type, action, and readability score where required by law. Copies of the actual form documents must be attached for individual and small group health benefit plans and must include page numbers.
- 2. In order to file a "Listing of New Policy Forms for Health Coverage" the carrier must complete the Form Schedule Tab in SERFF. The listing must include any new policy forms, application forms, endorsements or riders for any health benefit plan or stand-alone pediatric dental and/or health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, with a description of the form, unique form number for new forms, including the edition date for amended forms, the title of the program or product affected by the form, and the readability score where required by law.
- 3. In order to file an "Annual Report for Health Coverage Plans" the carrier must complete the Form Schedule Tab in SERFF. The report must include all policy forms, application forms, endorsements or riders, and/or health policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms. This annual report shall include a certification that the rates and classification of risks or subscribers pertaining to the policies, endorsements, riders, or applications are on file with the commissioner. Listing the readability score and attaching the actual forms is not required.

4. If a carrier uses the optional method of electronic dissemination of newly issued or renewed policy forms or endorsements, the carrier must comply with Colorado's Uniform Electronic Transactions Act (UETA) § 24-71.3-101, et seq., C.R.S. UETA guidance is provided by the Colorado Office of Information Technology and the Division.
5. Carriers shall not represent an existing policy form to be a new policy form, if the policy form is not being issued in connection with a substantially different new benefit. In the case of reasonable modifications, if an existing policy form is modified and it is not a new policy form, it will need to comply with the provisions of § 10-16-105.1(5), C.R.S., for reasonable modifications. For carriers who have opted to discontinue certain plans, new policy forms cannot have similar names or form numbers to any discontinued plan forms.

**B. Certification Requirements**

1. At least thirty-one (31) days prior to using any new form, each carrier, subject to the provisions of this regulation, shall file, in a format prescribed by the commissioner, a fully-executed "Colorado Health Coverage Certification Form for Listing of New Policy Forms (Form Health)", and complete the Form Schedule Tab in SERFF.
2. Not later than December 31 of each year, each carrier subject to the provisions of this regulation shall file an annual report of policy forms including a fully executed "Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)" and complete the Form Schedule Tab in SERFF.
3. Elements of certification: The elements of certification as determined by the commissioner, which must be included in the "Colorado Health Coverage Certification Form for Listing of New Policy Forms (Form Health)", and "Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)", are as follows:
  - a. The name of the carrier;
  - b. A statement that the officer signing the certification form is knowledgeable of the health coverage insurance being certified;
  - c. A statement that the officer signing the certification form has carefully reviewed the policy forms, subscription certificates, membership certificates, or other evidences of health care coverage identified on the Form Schedule Tab in SERFF;
  - d. A statement that the officer signing the certification form has read and understands each applicable law, regulation and bulletin;
  - e. A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncomplying form or contract;
  - f. A statement that the officer signing the certification form certifies:
    - (1) For the "Listing of New Policy Forms" for health benefit plans and stand-alone pediatric dental coverage, that the certifying officer has reviewed, signed and placed on file, and to the best of the officer's good faith, knowledge and belief, that the submitted forms provide all applicable mandated coverages and are in full compliance with all Colorado laws and regulations, and that copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner. The submitted forms must include:

- (a) New policy forms;
  - (b) Application forms (to include any health questionnaires used as part of the application process used by large group plans only);
  - (c) Endorsements and riders for any health benefit plan and/or stand-alone pediatric dental insurance policy; and
  - (d) Contracts, certificates, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado.
- (2) For "Annual Report for Health Coverage Plan" for health benefit plans and stand-alone pediatric dental plans, the documents identified in the Form Schedule Tab in SERFF, provide all applicable mandated coverages, and are in full compliance with all Colorado laws and regulations;
- g. The name and title of the officer signing the certification form and the date the certification form is signed;
- h. The original or electronic signature of the officer. Signature stamps, photocopies or a signature on behalf of the officer are not acceptable. Electronic signatures must be in compliance with § 24-71.3-101 et seq, C.R.S. and applicable regulations; and
- i. If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. This documentation is to be submitted with all filings.

**C. Required Submissions**

- 1. All policies, amendments, contracts, application forms, endorsements or riders, certificates, and other evidence of health coverage, must be filed with the Division at least thirty-one (31) days prior to issuance or deliverance of policies, certificates or evidence of coverage.
- 2. All carriers must submit a compliant form filing prior to giving forms to new or existing policyholders which differ from the forms on file with the Division.
- 3. All carriers must submit a compliant form filing on an annual basis, containing the items required in this regulation.
- 4. Each type of insurance must have a separate form filing. Form filings must not be combined with rate filings.
- 5. A separate filing must be submitted for each carrier. A single filing made for more than one carrier, or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan.



- 6. All grandfathered health benefit plan form filings must be submitted separately from non-grandfathered health benefit plan form filings.
- D. To be considered a complete filing, new or revised form filings for individual and small group health benefit plans and stand-alone pediatric dental plans must comply with the form filing procedures contained in Appendix A of this regulation.

#### **Section 6      Readability**

- A. Carriers writing health benefit plans must include the Flesch-Kincaid grade level or the Flesch Read Ease score in the electronic filing. The Flesch-Kincaid grade level shall not exceed the tenth (10th) grade level or the Flesch Read Ease score shall not be less than 50.
- B. Carriers may choose either the Flesch-Kincaid grade level formula or the Flesch Read Ease formula to generate a readability score. However, once a formula has been selected from these two (2) formulas, the selected formula shall be used consistently for all text being scored for that particular policy form.
- C. All policies, amendments, application forms, endorsements or riders, and other forms made a part of the policy by a carrier must either be scored as a separate form, or as part of the policy with which they will be used.
- D. For the purposes of the readability score, amendments, application forms, endorsements or riders that are made part of the policy, evidence of coverage, or certificate of coverage, are required to comply with the readability score. Cancellation notices, renewal notices, disclosure forms, and notices of reductions in coverage do not require a readability score.
- E. Carriers must provide all policy forms in a manner that is accessible and timely to individuals living with disabilities, or with limited English proficiency.

#### **Section 7      Severability**

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

#### **Section 8      Enforcement**

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

#### **Section 9      Effective Date**

This regulation shall become effective on April 15, 2014.

#### **Section 10     History**

Regulation effective October 1, 2013.  
Revised regulation effective April 15, 2014.

**APPENDIX A FORM FILING REQUIREMENTS FOR NEW AND REVISED NON-GRANDFATHERED INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS AND STAND-ALONE DENTAL PLANS OFFERING PEDIATRIC DENTAL COVERAGE**

1. Format: All required reports and documentation must be submitted through SERFF in a searchable PDF format.
2. Unless otherwise noted, carriers offering individual and small group health benefit plans, and stand-alone pediatric dental plans must follow the filing requirements in this appendix for plans offered inside and outside of Connect for Health Colorado.
3. Variability: Carriers may submit one base document, accompanied by a statement of variability, for all policy forms, per the following requirements:
  - a. Cost sharing information, including copayments, coinsurance, deductibles, and maximum out-of-pocket amounts, should be bracketed as variable amounts to include the entire possible range of minimum amounts for plans at all metal levels (as defined in Colorado Insurance Regulation 4-2-42);
  - b. Bracketed language must be complete and options must be identified in a statement of variability. Form filings that do not include an adequate explanation of bracketed ranges and language may be rejected;
  - c. Special requirements for Evidence of Coverage (EOC) forms:
    - (1) The EOC documents attached under the Form Schedule Tab in the Filing (Non-Binder) section of SERFF, as required in paragraph 4.b. of this appendix, will be reviewed by the Division for compliance with state and federal law. The Division will allow carriers to use variable language in these documents at the level of the Benefits Package, as defined by the federal Plans and Benefits Template in the Plan Management (Binder) section in SERFF;
    - (2) The EOC documents attached under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF, as required in paragraph 4.e. of this appendix, will be posted on the Connect for Health Colorado website. Connect for Health Colorado will allow carriers to use variable language in these documents at the Health Insurance Oversight System (HIOS) Standard Component Plan ID level. For plans offered through Connect for Health Colorado the EOC may be submitted in Spanish, but there is no requirement to do so; and
    - (3) Carriers offering stand-alone pediatric dental plans submit EOC documents, and otherwise comply with the requirements of paragraphs 4.a through 4.e of this appendix;
4. Submission Requirements for New Form Filings: Carriers must complete and submit the following information in SERFF in order for a form filing submission to be considered complete:
  - a. Carriers must complete all SERFF required data fields;
  - b. Carriers must complete the Form Name, Form Number, Form Type, Action, Readability Score data fields on the Form Schedule Tab, and attach copies of the following documents:
    - (1) Evidence of Coverage;

- (2) Uniform Application; and
  - (3) Policy forms, riders and endorsements;
- c. Carriers must attached copies of the following documents under the Supporting Documentation Tab in the Filing (Non-Binder) section in SERFF:
  - (1) Letter of Authority (if a carrier uses a third party to submit a form filing on its behalf); and
  - (2) Colorado Health Coverage Certification Form for Listing of New Policy Forms (Form Health).
- d. Carriers must complete and upload the Administrative Data Template under the Template Tab in the Plan Management (Binder) section of SERFF.
- e. Carriers offering plans through Connect for Health Colorado must complete and upload the following templates, under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF:
  - (1) Summary of Benefits and Coverage; and
  - (2) Evidence of Coverage.

**Regulation 4-2-42      CONCERNING ESSENTIAL HEALTH BENEFITS**

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

**Section 1      Authority**

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

**Section 2      Scope and Purpose**

The purpose of this regulation is to establish rules for the required inclusion of the essential health benefits in individual and small group health benefit plans in accordance with Article 16 of Title 10 of the Colorado Revised Statutes, and the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA).

### **Section 3      Applicability**

This regulation shall apply to all carriers offering individual and small group health benefit plans subject to the individual and group laws of Colorado and the requirements of the ACA. The requirements of this regulation do not apply to grandfathered health benefit plans.

### **Section 4      Definitions**

- A.      “Actuarial value” and “AV” means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a plan will cover, with calculations based on the provision of essential health benefits to a standard population.
- B.      “AV calculator” means, for the purposes of this regulation, the publicly available actuarial value (AV) calculator developed by the U.S. Department of Health and Human Services (HHS) and available electronically on the Center for Consumer Information & Insurance Oversight (CCIIO) website.
- C.      “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.
- D.      “Catastrophic plan” shall have the same meaning as found at § 10-16-102(10), C.R.S.
- E.      “Essential health benefits” and “EHB” shall have the same meaning as found at § 10-16-102(22), C.R.S.
- F.      “Essential health benefits package” shall have the same meaning as found at § 10-16-102(23), C.R.S.
- G.      “Exchange” shall have the same meaning as found at § 10-16-102(26), C.R.S.
- H.      “Federal law” shall have the same meaning as found at § 10-16-102(29), C.R.S.
- I.      “Grandfathered health benefit plan” shall have the same meaning as found at § 10-16-102(31), C.R.S.
- J.      “Habilitative services” means, for the purposes of this regulation, services that help a person retain, learn or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado’s EHB benchmark plan.
- K.      “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.
- L.      “Premium adjustment percentage” means, for purposes of this regulation, the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance, as published in the annual HHS “Notice of benefits and payment parameters.”

### **Section 5      Essential Health Benefits**

- A.      Carriers offering non-grandfathered individual and small group health benefit plans inside or outside of the Exchange must include the essential health benefits package.
  - 1.      Carriers must provide benefits that are substantially equal to Colorado’s EHB-benchmark plan in the following ten (10) categories:
    - a.      Ambulatory patient services, which must include, at a minimum:

- (1) Primary care to treat an illness or injury;
  - (2) Specialist visits;
  - (3) Outpatient surgery;
  - (4) Chemotherapy services;
  - (5) Radiation therapy;
  - (6) Home infusion therapy;
  - (7) Home health care;
  - (8) Outpatient diagnostic laboratory, x-ray, and pathology services;
  - (9) Sterilization;
  - (10) Treatment of cleft palate and cleft lip conditions; and
  - (11) Oral anti-cancer medications.
- b. Emergency services, which must include, at a minimum:
  - (1) Emergency room – facility and professional services;
  - (2) Ambulance services; and
  - (3) Urgent care treatment services.
- c. Hospitalization services, which must include:
  - (1) Inpatient medical and surgical care;
  - (2) Organ and tissue transplants (transplants may be limited to specified organs);
  - (3) Chemotherapy services;
  - (4) Radiation services;
  - (5) Anesthesia services; and
  - (6) Hospice care.
- d. Laboratory and radiology services, which must include:
  - (1) Laboratory tests, x-ray, and pathology services; and
  - (2) Imaging and diagnostics, such as MRIs, CT scans, and PET scans.
- e. Maternity and newborn care services, including state and federally required benefits for hospital stays in connection with childbirth, which must include:
  - (1) Pre-natal and postnatal care;

- (2) Delivery and inpatient maternity services; and
  - (3) Newborn well child care.
- f. Mental health, substance abuse disorders, and behavioral health treatment services rendered on an inpatient or outpatient basis, which must include:
  - (1) Benefits for treating alcoholism and drug dependency;
  - (2) Benefits for mental health services;
  - (3) Behavioral health treatment;
  - (4) Benefits for biologically based mental illness and mental disorder treatment that are no less extensive than the coverage provided for a physical illness, pursuant to § 10-16-104(5.5), C.R.S.; and
  - (5) Outpatient hospital and physician services.
- g. Pediatric services, which must include:
  - (1) Preventive care services;
  - (2) Immunizations;
  - (3) One (1) comprehensive routine eye exam per year, to age nineteen (19);
  - (4) Routine hearing exams to age nineteen (19);
  - (5) Hearing aids to age eighteen (18), pursuant to § 10-16-104(19), C.R.S.; and
  - (6) Children's dental anesthesia, pursuant to § 10-16-104(12), C.R.S.
- h. Prescription drugs, which must include:
  - (1) Retail services;
  - (2) Mail services (home delivery);
  - (3) Contraceptive methods approved by the Food and Drug Administration (FDA); and
  - (4) To meet the EHB requirement for prescription drug benefits, carriers must offer coverage that includes at least the greater of:
    - (a) One (1) drug in every United States Pharmacopeia (USP) category and class; or
    - (b) The same number of prescription drugs in each category and class as the EHB-benchmark plan.

- i. Preventive services required by state and/or federal mandate, which are not subject to deductibles, copayments, or coinsurance, include, but are not limited to:
  - (1) Services related to contraception, including, but not limited to FDA-approved methods, and including the services related to follow-up and management of side effects, counseling for continued adherence, and device removal; and
  - (2) Age-appropriate immunizations and vaccines for children, adolescents, and adults in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP).
- j. Rehabilitative and habilitative services and devices, which must include:
  - (1) No less than twenty (20) visits per calendar year, per therapy, for physical, speech, and occupational therapy for:
    - (a) Habilitative services; and
    - (b) Rehabilitative services.

Habilitative and rehabilitative service visits are cumulative, such that a carrier must provide, at a minimum, no less than sixty (60) visits for habilitative services, and no less than sixty (60) visits for rehabilitative services per calendar year.
  - (2) Cardiac rehabilitation services;
  - (3) Pulmonary rehabilitation services;
  - (4) Durable medical equipment;
  - (5) Arm and leg prosthetics;
  - (6) Inpatient and outpatient habilitative services;
  - (7) No less than one hundred (100) days of skilled nursing services annually;
  - (8) No less than two (2) months of inpatient rehabilitation annually, and no less than sixty (60) days for plans issued or renewed on or after January 1, 2016;
  - (9) Autism spectrum disorder services; and
  - (10) Physical, occupational, and speech therapy for congenital defects for children up to age six (6), as required by § 10-16-104(1.7), C.R.S.
- 2. Carriers seeking to include pediatric dental EHB coverage within a health benefit plan, or carriers offering a stand-alone pediatric dental plan that meets EHB requirements, must include the following eligible services, subject to plan benefit limitations, in order to meet the EHB requirements for pediatric dental coverage:
  - a. Diagnostic and preventive procedures, which must include:

- (1) Oral exams and evaluations;
    - (2) Full mouth, intra-oral, and panoramic x-rays;
    - (3) Bitewing x-rays;
    - (4) Routine cleanings;
    - (5) Fluoride treatments;
    - (6) Space maintainers;
    - (7) Sealants; and
    - (8) Palliative treatment.
  - b. Basic restorative services, which must include:
    - (1) Amalgam fillings;
    - (2) Resin and composite fillings;
    - (3) Crowns;
    - (4) Pin retention; and
    - (5) Sedative fillings.
  - c. Oral surgery, consisting of extractions.
  - d. Endodontics, consisting of:
    - (1) Surgical services; and
    - (2) Root canal therapy.
  - e. Medically necessary orthodontia and medically necessary prosthodontics for the treatment of cleft lip and cleft palate.
  - f. Implants, denture repair and realignment, dentures and bridges, non-medically necessary orthodontia, and periodontics are not considered a part of the pediatric dental EHB.
- 3. Carriers must limit cost-sharing for EHB coverage in accordance with state and federal law.
  - a. Cost-sharing (or maximum out-of-pocket limits) for individual and small group plans must not exceed the annual out-of-pocket limit set by federal law. For managed care plans, out-of-network deductibles and out-of-pocket maximums do not count toward these cost sharing limits.



- b. For plan years after 2015, cost sharing limits for individual and small group plans may not be increased beyond the annual premium adjustment percentage for individuals, and no more than twice the individual amount for family plans. Increases in annual deductibles must be in multiples of fifty (50) dollars, and if not, must be rounded to the next lowest multiple of fifty (50) dollars.
    - c. Cost-sharing (or maximum out-of-pocket limits) for stand-alone pediatric dental plans must not exceed the annual out-of-pocket limit set by federal law. For managed care plans, out-of-network deductibles and out-of-pocket maximums do not count toward these cost sharing limits.
    - d. The Division will annually publish the federally established annual premium adjustment percentages and annual out-of-pocket limits for medical and dental plans, as determined by HHS.
  - 4. Carriers must offer health benefit plans that meet state and federally defined levels of coverage.
    - a. Carriers must offer plans that meet at least one (1) of the following metal tiers of coverage:
      - (1) Bronze level: benefits actuarially equivalent to sixty percent (60%) of the full actuarial value of the benefits provided under the plan;
      - (2) Silver level: benefits actuarially equivalent to seventy percent (70%) of the full actuarial value of the benefits provided under the plan;
      - (3) Gold level: benefits actuarially equivalent to eighty percent (80%) of the full actuarial value of the benefits provided under the plan; or
      - (4) Platinum level: benefits actuarially equivalent to ninety (90%) of the full actuarial value of the benefits provided under the plan.
    - b. Carriers are allowed a de minimis range of +/- two percentage (2%) points for each metal tier.
    - c. Carriers offering health benefit plans at any of the levels of coverage listed in Section 5.A.4.a. of this regulation must offer child-only plans at that same level.
    - d. Carriers may offer a catastrophic plan that does not provide a bronze, silver, gold, or platinum level of coverage to certain qualified individuals.
  - 5. Benefits that are excluded from EHB, even though they may be covered by the EHB-benchmark plan, include:
    - a. Routine non-pediatric dental services;
    - b. Routine non-pediatric eye exam services;
    - c. Long-term/custodial nursing home care benefits; and
    - d. Non-medically necessary orthodontia.
  - 6. Although the EHB-benchmark plan provides coverage for abortion services, no health benefit plan must cover such services as part of the requirement to cover EHB.

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7. Carriers offering stand-alone non-pediatric dental plans that are offered in conjunction with a health benefit plan, or are offered as a stand-alone policy, need not comply with the requirements of Section 5.A.2. of this regulation.
- B. Carriers must use actuarial value (AV) to determine the level of coverage of a health benefit plan. The AV is the percentage of total average costs for covered benefits that a plan will cover, and must be calculated based on the provision of EHB to a standard population.
1. For standard plan designs, carriers must use the AV calculator developed by HHS to determine AV.
  2. Carriers offering plans with benefit designs that cannot be accommodated by the AV calculator may alternatively:
    - a. Decide how to adjust the plan's benefit design (for calculation purposes only) to fit the parameters of the calculator, and have a member of the American Academy of Actuaries certify that the methodology to fit the parameters of the AV calculator was in accordance with generally accepted actuarial principles and methodologies; or
    - b. Use the AV calculator for the plan design provisions that correspond to the parameters of the calculator, and have a member of the American Academy of Actuaries calculate appropriate adjustments to the AV as determined by the AV calculator for the plan design features that deviate substantially, in accordance with generally accepted actuarial principles and methodologies.
- C. Substitution of Benefits
1. Carriers are permitted to substitute EHB if the following conditions are met:
    - a. The substituted benefit must be actuarially equivalent to the benefit that is being replaced. Carriers must submit evidence of actuarial equivalence that is:
      - (1) Certified by a member of the American Academy of Actuaries;
      - (2) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
      - (3) Based on a standardized population; and
      - (4) Determined regardless of cost-sharing.
    - b. A benefit substitution may be made only within the same EHB category (substitutions across categories are not permitted); and
    - c. Prescription drug benefits cannot be substituted.
- D. Prohibition on Discrimination
1. Carriers may not offer benefit plans that, either through their design or implementation, discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other medical conditions.
  2. Carriers may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

3. Carriers may not offer plans with benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.

**E. Drug/Formulary Review**

Carriers must submit their formularies to the Division annually, by June 30 of each year. If a formulary changes by more than five percent (5%) in a calendar year, the carrier must submit a filing to the Division supporting that its formulary has the required number of drugs in each category to comply with the EHB requirement.

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

**Section 6 Preventive Services Requirements**

- A.** Carriers must provide coverage for any new preventive service receiving a USPSTF A or B recommendation, changes adopted by the ACIP, and/or changes published by the Health Resources and Services Administration (HRSA) no later than the plan year that begins on or after one (1) year after the date the recommendation or change is issued, adopted or published.
- B.** The Division shall publish, by bulletin, the list of covered preventive services in accordance with:
1. The "USPSTF A and B Recommendations," published by the United States Preventive Services Task Force (USPSTF);
  2. The preventive services mandated by Colorado statute; and
  3. The women's preventive service guidelines published by the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services.
- C.** The Division shall review this bulletin no less frequently than annually to determine if amendments are required. If it is determined that amendments are required, any changes made to the list of covered preventive services will be incorporated to include:
1. New preventive services added to Colorado statute;
  2. New A or B recommendations or changes to existing preventive service recommendations adopted by the USPSTF; and/or
  3. New guidelines or changes to existing guidelines published by HRSA.

**Section 7 Incorporation by Reference**

The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices, as published by the Advisory Committee on Immunization Practices shall mean age-appropriate immunization and vaccine schedules as published on the effective date of this regulation and do not include later amendments to, or editions of, the age-appropriate immunization and vaccine schedules. The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Advisory Committee on Immunization Practices website at <http://www.cdc.gov/vaccines/schedules/hcp/index.html>. Certified copies of the age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices are available from the Colorado Division of Insurance for a fee.

## **Section 8 Severability**

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

## **Section 9 Enforcement**

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

## **Section 10 Effective Date**

This regulation shall become effective on March 15, 2015.

## **Section 11 History**

Regulation effective October 1, 2013.  
Amended regulation effective March 15, 2015.

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

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Individual Enrollment Periods
Section 6	Group Enrollment Periods
Section 7	Incorporation by Reference
Section 8	Severability
Section 9	Enforcement
Section 10	Effective Date
Section 11	History

## **Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105(2)(b), 10-16-105.7(1)(e), 10-16-105.7(3)(c), and 10-16-109, C.R.S.

## **Section 2 Scope and Purpose**

The purpose of this regulation is to establish rules governing enrollment periods for individual and group health benefit plans in accordance with Article 16 of Title 10 of Colorado Revised Statutes, and the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA).

## **Section 3 Applicability**

This regulation shall apply to all carriers offering individual and/or group health benefit plans subject to the individual and group laws of Colorado and the requirements of the ACA. This regulation does not apply to those health benefit plans that have not yet become subject to the provisions of HB13-1266.

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**Section 4        Definitions**

- A.        “Calendar year” means, for the purpose of this regulation, a year beginning on January 1 and ending on December 31.
- B.        “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.
- C.        “Creditable coverage” shall have the same meaning as found at § 10-16-102(16), C.R.S.
- D.        “Days” mean, for the purpose of this regulation, calendar days, not business days.
- E.        “Designated beneficiary agreement” shall have the same meaning as found at § 15-22-103(2), C.R.S.
- F.        “Qualified individual” means, for the purpose of this regulation, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.
- G.        “Exchange” shall have the same meaning as found at § 10-16-102(26), C.R.S.
- H.        “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

**Section 5        Individual Enrollment Periods**

- A.        Carriers offering individual health benefit plans must accept every eligible individual who applies for coverage, agrees to make the required premium payments and abide by the reasonable provisions of the plan, although carriers may choose to restrict enrollment to open or special enrollment periods.
- B.        Carriers offering individual health benefit plans must display continuously and prominently on their web site:
  - 1.        Notice of open enrollment dates;
  - 2.        Notice of special enrollment for qualifying and triggering events;
  - 3.        Notice of the enrollment periods for each qualifying and triggering event; and
  - 4.        Instructions on how to enroll.
- C.        Open enrollment periods.
  - 1.        The open enrollment period for plans effective on or after January 1, 2016 shall begin on November 1, 2015, and extend through January 31, 2016.
  - 2.        Carriers must ensure that coverage is effective:
    - a.        January 1 for health benefit plans purchased on or before December 15 of the open enrollment period;
    - b.        February 1 for health benefit plans purchased between December 16 through January 15 of the open enrollment period; and
    - c.        March 1 for health benefit plans purchased between January 16 through January 31 of the open enrollment period.

3. The benefit year for individual health benefit plans purchased during the annual open enrollment period is a calendar year.
4. During open enrollment periods, carriers must offer guarantee-issue child-only health benefit plans to all applicants under the age of 21.

**D. Special enrollment periods.**

Carriers must establish special enrollment periods for individuals who experience triggering events, pursuant to § 10-16-105.7, C.R.S.

1. Following a triggering event, a carrier must provide a special enrollment period of sixty (60) days.
2. When an individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the thirty (30) calendar days prior to the date of the triggering event, unless otherwise noted in subparagraph 4. of this Section 5.D., with coverage beginning no earlier than the day the triggering event occurs to avoid a gap in coverage. The individual must be able to provide written documentation to support the date of the triggering event at the time of plan selection. The effective date of this enrollment must comply with the coverage effective dates found in Section 5.D.5. of this regulation.
3. When a qualified individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs to avoid a gap in coverage. The individual must be able to provide written documentation to support the date of the triggering event at the time of plan selection. The effective date of this enrollment must comply with the coverage effective dates found in Section 5.D.5. of this regulation.
4. Triggering events are:
  - a. An individual or his or her dependent involuntarily losing existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium. Such individual or dependent may apply for enrollment in a new health benefit plan during the sixty (60) calendar days before and after the effective date of the loss of coverage;
  - b. An individual loses pregnancy-related Medicaid coverage. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or
  - c. When an Exchange enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the Exchange enrollee, or his or her dependent, dies. This triggering event will apply to all individuals beginning January 1, 2017.
  - d. An individual or his or her dependent losing other coverage as described under Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. § 301 et seq.). Such individual or dependent may apply once during a calendar year for enrollment in a new health benefit plan during the sixty (60) calendar days before and after the effective date of the loss of coverage;

- e. An individual gaining a dependent or becoming a dependent through marriage, civil union, birth, adoption, or placement for adoption, placement in foster care, through a child support order or other court order, or by entering into a designated beneficiary agreement if the carrier offers coverage to designated beneficiaries;
- f. An individual's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or the Exchange;
- g. An individual demonstrating to the Commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual;
- h. A qualified individual who:
  - (1) Becomes newly eligible, or an Exchange enrollee who is newly eligible or ineligible, for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange;
  - (2) Has a dependent enrolled in the same qualified health plan who is determined to be newly eligible or ineligible for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange; or
  - (3) Is enrolled in an eligible employer-sponsored plan and is determined to be newly eligible for the federal advance payment tax credit based in part on a finding that such individual is ineligible for coverage in an eligible employer-sponsored plan that provides minimum creditable coverage, including as a result of his or her employer discontinuing or changing coverage within the next sixty (60) days, provided the enrollee is able to terminate his or her existing coverage. This enrollee may apply for enrollment in a new health benefit plan during the sixty (60) calendar days before and after the effective date of the loss of coverage.
- i. An individual gaining access to other creditable coverage as a result of a permanent change in residence;
- j. A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Children's Basic Health Plan;
- k. An individual becoming ineligible under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.);
- l. An individual, who was not previously a citizen, a national, or a lawfully present individual, gaining such status;
- m. An Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.), may enroll in a qualified health plan or change from one qualified health plan to another one time per month; or
- n. An individual or his or her dependent currently enrolled in an individual or group non-calendar year health benefit plan may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the effective date of the loss of coverage, which is the last day of the plan or policy year.

5. Coverage effective dates.
  - a. In the case of marriage, civil union, or in the case where an individual loses creditable coverage, coverage must be effective no later than the first day of the month following plan selection.
  - b. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage must be effective on either:
    - (1) The date of the event; or
    - (2) The first day of the month following the birth, adoption, placement for adoption, or placement in foster care, if requested by the primary individual policyholder.
  - c. In the case of an involuntary loss of existing creditable coverage in accordance with Section 5.D.4.a. of this regulation, coverage shall become effective either:
    - (1) On the first day of the month following the triggering event if plan selection is made on or before the day of the triggering event;
    - (2) In accordance with the effective dates specified in Section 5.D.5.f. and g. of this regulation if a plan selection is made after the day of the triggering event; or
    - (3) At the option of the Exchange, on the first day of the month following plan selection when plan selection is made after a triggering event.
  - d. In the case of gaining a dependent or becoming a dependent through a court order, coverage shall become effective either:
    - (1) On the date the court order is effective; or
    - (2) In accordance with the effective dates specified in Section 5.D.4.f. and g. of this regulation at the election of the primary individual policyholder.
  - e. The effective date of coverage for triggering events found in Section 5.D.3.d. and e. of this regulation must be an appropriate date based upon the circumstances of the special enrollment period.
  - f. In the case of all other triggering events where individual coverage is purchased between the first and fifteenth day of the month, coverage shall become effective no later than the first day of the following month.
  - g. In the case of all other triggering events where individual coverage is purchased between the sixteenth and last day of the month, coverage shall become effective no later than the first day of the second following month.

**E. Notification requirements.**

Carriers offering individual health benefit plans during open enrollment periods must provide the notice found in Appendix A to their current individual policyholders no later than thirty (30) days prior to the start of each annual open enrollment period.



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**Section 6      Group Enrollment Periods**

- A. Carriers that offer small group health benefit plans must guarantee-issue small group health benefit plans throughout the year to any eligible small group that applies for a plan, agrees to make the required premium payments, and abide by the reasonable provisions of the plan, except as noted below.
- B. Special enrollment periods for small employers.
  - 1. For small employers that are unable to comply with employer contribution or group participation rules at the time of initial application, carriers may limit the availability of coverage for a group it has declined to an enrollment period that begins on November 15 and ends on December 15 of each year.
  - 2. Coverage must be effective consistent with the dates listed below, unless the initial premium payment is not received by the carrier's cut-off date.
    - a. Carriers cannot establish a waiting period of more than ninety (90) days.
    - b. If a fully completed application that includes plan selection is received by the carrier between the first and the fifteenth day of the month, the first effective day of the health benefit plan will be no later than the first day of the following month.
    - c. If a fully completed application that includes plan selection is received between the sixteenth and last day of the month, the first effective day of the health benefit plan will be no later than the first day of the second following month.
- C. Special enrollment periods for employees of small and large employer group plans.
  - 1. Carriers must establish special enrollment periods in the group health benefit plan for individuals who experience any of the following qualifying events pursuant to § 10-16-105.7(3)(b)(I), C.R.S.:
    - a. Loss of coverage due to:
      - (1) The death of a covered employee;
      - (2) The termination or reduction in the number of hours of the employee's employment;
      - (3) The covered employee becoming eligible for benefits under Title XVIII of the Federal Social Security Act (42 U.S.C. § 301 et seq.); or
      - (4) The divorce or legal separation from the covered employee's spouse or partner in a civil union.
    - b. Becoming a dependent through marriage, civil union, birth, adoption, or placement for adoption, or placement in foster care;
    - c. Becoming a dependent of a covered person by entering into a designated beneficiary agreement, or pursuant to a court or administrative order mandating that the individual be covered;

- d. Losing other creditable coverage due to:
    - (1) Termination of employment or eligibility for coverage, regardless of eligibility for COBRA or state continuation;
    - (2) A reduction in the number of hours of employment;
    - (3) Involuntary termination of coverage; or
    - (4) Reduction or elimination of his or her employer's contributions toward the coverage.
  - f. Losing coverage under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.) and then requesting coverage under an employer's group health benefit plan within sixty (60) days of the loss of coverage;
  - g. An employee or dependent becoming eligible for premium assistance under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.) or the Children's Basic Health Plan; or
  - h. A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Children's Basic Health Plan, and the parent or legal guardian requests enrollment of the dependent in a health benefit plan within sixty (60) days of the disenrollment or determination of ineligibility.
- 2. Individuals in the group market shall have a thirty (30) day special enrollment period that begins on the date the qualifying event occurs, except as provided in Section 6.C.1.f. and g. of this regulation, which provide a sixty (60) day special enrollment period.
  - 3. When an individual in the group market is notified or becomes aware of a qualifying event that will occur in the future, he or she may apply for coverage during the thirty (30) calendar days prior to the effective date of the qualifying event, with coverage beginning no earlier than the day the qualifying event occurs to avoid a gap in coverage. The individual must be able to provide written documentation to support the effective date of the qualifying event at the time of enrollment. The effective date of this enrollment must comply with the coverage effective dates found in Section 6.C.4. of this regulation.
  - 4. Coverage effective dates.
    - a. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage must be effective on the date of the event.
    - b. In the case of marriage, civil union, or other qualifying events, coverage must be effective no later than the first day of the following month after the date the Exchange or the carrier receives a completed enrollment form.

## **Section 7      Incorporation by Reference**

The Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq. (2010)), published by the Indian Health Service shall mean the “Indian Health Care Improvement Act” as published on the effective date of this regulation and does not include later amendments to or editions of the “Indian Health Care Improvement Act.” A copy of the “Indian Health Care Improvement Act” may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Indian Health Service website at [http://www.ihs.gov/ihcia/documents/home/USCode\\_Title25\\_Chapter%2018.pdf](http://www.ihs.gov/ihcia/documents/home/USCode_Title25_Chapter%2018.pdf). A certified copy of the “Indian Health Care Improvement Act” may be requested from the Colorado Division of Insurance for a fee.

## **Section 8      Severability**

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

## **Section 9      Enforcement**

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

## **Section 10      Effective Date**

This regulation shall become effective on November 1, 2015.

## **Section 11      History**

Emergency regulation 13-E-13 effective October, 31, 2013.

Regulation effective February 1, 2014.

Amended regulation effective August 15, 2014.

Amended regulation effective November 1, 2015.

## **APPENDIX A**

### **Annual Open Enrollment Period Notice for Individual Health Benefit Plans**

We would like to let you know that your annual open enrollment period starts this year on [Open Enrollment Start Date]. Your open enrollment period will last until [Open Enrollment End Date]. During the open enrollment period you will be able to purchase new health insurance for the coming year.

You have two choices:

- You can continue with your current plan, where you will not need to take any action; or
- You can enroll in a new plan during the open enrollment period.

If you decide to choose a new plan:

- You can choose your new plan from us, or any other carrier offering plans; or
- You may purchase a new plan through Connect for Health Colorado, where you may qualify for federal financial assistance ([www.connectforhealthco.com](http://www.connectforhealthco.com)).

*Make sure you follow the termination notice requirements in your current plan so that you will be able to avoid a gap in coverage by ending your old plan and beginning your new plan on the appropriate dates.*

You can contact us or your insurance advisor for assistance and additional information. [Insert carrier contact information]

**Regulation 4-2-44      TRANSITION OF INDIVIDUAL HEALTH BENEFIT PLANS, BASIC AND STANDARD HEALTH BENEFIT PLANS, BUSINESS GROUP OF ONE PLANS, AND CONVERSION PLANS [Repealed eff. 01/01/2016]**

**Regulation 4-2-45      UNIFORM INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLAN APPLICATIONS**

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

**Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-107.5(1), and 10-16-109, C.R.S.

**Section 2      Scope and Purpose**

The purpose of this regulation is to promulgate rules concerning the uniform individual and small group health benefit plan applications.

**Section 3      Applicability**

This regulation applies to all carriers offering individual and small group health benefit plans that are subject Colorado insurance laws. This includes carriers offering coverage under Parts 2, 3, and 4 of Article 16 of Title 10 of the Colorado Revised Statutes.

**Section 4      Definitions**

- A. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.
- B. "Uniform Individual Application" means, for purposes of this regulation, the individual application developed and published by the Division of Insurance (Division) for use by carriers in collecting information from an applicant to determine what plans are appropriate for the applicant to consider.
- C. "Uniform Small Group Application" means, for purposes of this regulation, the small group application developed and published by the Division of Insurance (Division) for use by carriers in collecting information from employees to determine what plans are appropriate for the employee to consider.

**Section 5 Rules**

- A. Carriers must comply with the following requirements concerning uniform application forms:
1. All carriers offering individual health benefit plans outside of the Exchange must use the Uniform Individual Application when collecting enrollment information from consumers. The Uniform Individual Application can be found in Appendix A of this regulation.
  2. All carriers offering individual health benefit plans within the Exchange will use the Uniform Individual Application for the non-electronic collection of enrollment information from consumers.
  3. All carriers offering small group health benefit plans must use the Uniform Small Group Application when collecting enrollment information from employees and their dependents.
    - a. This application will be utilized by the Exchange as the non-electronic enrollment application for small group employees in the Small Business Health Options Program (SHOP).
    - b. The Uniform Small Group Application can be found in Appendix B of this regulation.
  4. Carriers may not alter, modify, or change the uniform applications developed by the Division.
  5. Carriers may not add logos or other graphics or text to the uniform applications.
- B. The Exchange may require additional information, through the use of an electronic application or a supplemental questionnaire, to collect information to comply with federal law for on-Exchange products.

**Section 6 Severability**

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

**Section 7 Enforcement**

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

**Section 8 Effective Date**

This regulation shall become effective on October 15, 2013.

**Section 9 History**

New regulation effective October 15, 2013.



Division of Insurance

COLORADO UNIFORM INDIVIDUAL APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's initial application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at [www.connectforhealthco.com](http://www.connectforhealthco.com).

COVERAGE INFORMATION	
Application Type:	<input type="checkbox"/> New Coverage <input type="checkbox"/> Change/Modification to Existing Coverage <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Special Enrollment*
Requested Effective Date:	____/____/____ (MM/DD/YYYY)

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

PRIMARY APPLICANT/INSURED INFORMATION	
Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.	
First Name:	Middle Initial: Last Name:
Social Security #:	Date of Birth: / / Current Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Physical Address:	City:
County:	State: Zip:
Mailing Address (if different):	City:
County:	State: Zip:
Home Phone:	Alternate Phone: Email:
Are you (check one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law* <input type="checkbox"/> Civil Union* <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Under 21	
Are you or is anyone in your family American Indian or Alaskan Native? <input type="checkbox"/> Yes <input type="checkbox"/> No	
* A common law, civil union, or designated beneficiary certification may be required by the carrier	
Employer Name and Address:	Work Phone:

ADDITIONAL APPLICANTS						
Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26 (older if medically disabled) are applying for coverage. If a dependent child is applying as an individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet.						
* Social Security Numbers (or document numbers for any legal immigrants) are needed for anyone applying for health insurance, missing numbers will be requested after enrollment						
Name (First, MI, Last)	Sex	Social Security #	Relationship	Disabled	Birth Date (MM/DD/YY)	Employer Name and Position
	<input type="checkbox"/> M <input type="checkbox"/> F		SPOUSE/PARTNER			
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do(es) the child(ren) named within the application live with you at the same physical address shown above? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, complete below)						
Child(ren)'s Name:	Mailing Address (if different):					
City:	County:	State:	Zip:			
Home Phone:	Alternate Phone:	Email:				

Primary Applicant Name: _____				
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Name of the Legal Guardian or Parent responsible for carrying health insurance for the child: _____				
If the primary applicant is under the age of 21 if different from above, provide the name and mailing address of the legal guardian or custodial parent:				
Legal Guardian or Custodial Parent's Name: _____		Mailing Address (if different): _____		
City: _____	County: _____	State: _____	Zip: _____	
Home Phone: _____	Alternate Phone: _____	Email: _____		

  

TOBACCO USE				
<p><i>Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."</i></p> <p>Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.</p>				
Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars	_____	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars	_____	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars	_____	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars	_____	_____

  

MEDICARE/MEDICAID INFORMATION	
Is any applicant enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of person covered by Medicare: _____. For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.	
Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.	

  

CURRENT MEDICAL COVERAGE				
Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No (Dental Coverage in next Section)				
Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type
If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain: _____				



Primary Applicant Name: \_\_\_\_\_

CERTIFICATION OF DENTAL INSURANCE COVERAGE	
(Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No <small>Note: you may be required provide proof that you have obtained coverage before this policy will be approved</small>
TERMS AND CONDITIONS	

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐ Yes ☐ No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:
Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:



Primary Applicant Name: \_\_\_\_\_

**AGENT/PRODUCER INFORMATION**

*This section is to be completed by Agent or Producer.*

Agent / Agency of Record: (for commissions and correspondence)

Writing Agent / Producer:

Name (print):

Name (print):

Agent ID # (NPR):

Agent ID # (NPR):

Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐ Yes ☐ No

As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.

Writing Agent Signature

Date

**DISCLOSURES**

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at <http://www.dora.colorado.gov/insurance>. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant: \_\_\_\_\_

Date Signed: \_\_\_\_\_



Division of Insurance

COLORADO UNIFORM EMPLOYEE APPLICATION FOR SMALL GROUP HEALTH BENEFIT PLANS

*This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.*

COVERAGE INFORMATION									
Application Type:		<input type="checkbox"/> New Coverage <input type="checkbox"/> Change/Modification to Existing Policy <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Special Enrollment*							
<small>* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: <a href="http://www.dora.colorado.gov/DOI/HealthApp">www.dora.colorado.gov/DOI/HealthApp</a></small>									
EMPLOYER INFORMATION									
Employee Name:					Employer Name:				
Proposed Effective Date:					Group Number (if known):				
EMPLOYEE INFORMATION									
Employee Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.									
First Name:			Middle Initial:		Last Name:				
Social Security #:			Date of Birth:		Current Age:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Address:			City:						
County:			State:		Zip:				
Mailing Address (if different):			City:						
County:			State:		Zip:				
Home Phone:			Email:		<input type="checkbox"/> Home <input type="checkbox"/> Work				
What is your job title at your current employer?					Work Phone:				
What was your first day of employment?					How many hours, on average, do you work each week?				
Are you (check one):		<input type="checkbox"/> Single		<input type="checkbox"/> Married		<input type="checkbox"/> Common Law*		<input type="checkbox"/> Civil Union*	
		<input type="checkbox"/> Designated Beneficiary*		<input type="checkbox"/> Legally Separated		<input type="checkbox"/> Divorced		<input type="checkbox"/> Widow or Widower	
<small>* A common law, civil union, or designated beneficiary certification may be required by the carrier</small>									
Are you on COBRA or State Continuation?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Start Date:		Stop Date:		
TYPE OF HEALTH COVERAGE									
List all dependents (spouse/partner and child(ren)) applying for coverage. If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).									
Please select the type of health insurance coverage for which you are applying: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family									
DEPENDENT INFORMATION (list all dependents to be covered)									
Name (First, MI, Last)	Sex	Social Security Number	Relationship	Disabled	Birth Date (MM/DD/YY)				
	<input type="checkbox"/> M <input type="checkbox"/> F		SPOUSE/PARTNER						
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No					

Employee Name:	Employer Name:
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TOBACCO USE				
<p><i>Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."</i></p> <p>Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.</p>				
Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		

EMPLOYEE/DEPENDENT WAIVER OF COVERAGE		
<p>Complete this section ONLY if you are not enrolling yourself or your spouse/partner or dependents. Waiver must be completed for all of your dependents to be eligible for enrollment on this plan in the event of changing circumstances. I understand that I am eligible to apply for group health coverage through my employer. I do NOT want, and hereby waive, group health coverage for:</p>		
	Name (Last, First, MI)	Birth Date (Mo/Day/Year)
Employee		
Spouse/Partner		
Dependent 1		
Dependent 2		
Dependent 3		
<p>I am waiving group health coverage for myself and/or the dependents listed above because (check all that apply, copy of ID card may be required):</p> <p> <input type="checkbox"/> I am covered under my spouse/partner's group policy.  <input type="checkbox"/> My spouse/partner is covered under another plan (including this plan, if spouse/partner is also an employee).  <input type="checkbox"/> My dependents are covered under another plan.  <input type="checkbox"/> I wish to continue other coverage obtained through an Individual Plan or Medicare  <input type="checkbox"/> Other (Please explain): _____                 </p>		
<p><b>WAIVER:</b> I certify that I have been given the opportunity to apply for group health coverage and decline to enroll as indicated above, on behalf of myself, my spouse/partner and my dependent child(ren). I understand that by signing this waiver, I, my spouse/partner, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the carrier(s) into waiving or declining the group health coverage. If in the future I apply for coverage, I, my spouse/partner, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of coverage for up to 12 months.</p> <p>I understand that if I am declining enrollment for myself, my spouse/partner, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse/partner, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within 30 days after my other health coverage ends or a qualifying event occurs. If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until my company's Open Enrollment period. I understand that I can obtain information related to my enrollment eligibility from my employer or small group health carrier.</p>		
Signature of Employee:		Date Signed:



Employee Name: _____	Employer Name: _____
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MEDICARE INFORMATION	
<p>If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). A copy of your ID card may be required.</p> <p>Are you, your spouse/partner or your child(ren) covered by:</p> <p>Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No      Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No      Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," reason for Medicare: <input type="checkbox"/> 65+ Eff. Date _____ <input type="checkbox"/> Disability Eff. Date _____</p> <p><input type="checkbox"/> End-Stage Renal Disease (ESRD) Eff. Date _____ <input type="checkbox"/> Disability and ESRD Eff. Date _____</p> <p>Name of person covered by Medicare: _____</p>	

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

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

Employee Name:	Employer Name:
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**TERMS AND CONDITIONS**

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado small employer carrier's other rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s).

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) to determine eligibility for coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

Signature of Employee:  \_\_\_\_\_ Date Signed: \_\_\_\_\_

**DISCLOSURES**

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO ANY SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS, AND SATISFIES THE OTHER PROVISIONS OF THE HEALTH BENEFIT PLAN.

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at <http://dora.colorado.gov/insurance>. For questions regarding coverage or enrollment please see your employer.



**Regulation 4-2-46      CONCERNING PREMIUM RATE SETTING FOR GRANDFATHERED  
INDIVIDUAL, SMALL GROUP, AND LARGE GROUP HEALTH BENEFIT PLANS AND  
STUDENT HEALTH COVERAGE**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Requirements to Maintain Grandfathered Status and Recordkeeping
Section 6	General Rate Filing Requirements
Section 7	Actuarial Memorandum
Section 8	Premium Rate Setting for Small Group Health Benefit Plans
Section 9	Use of Composite Rates for Small Group Health Benefit Plans
Section 10	Rate Filings and Actuarial Certifications for Small Group Health Benefit Plans
Section 11	Additional Rate Filing Requirements by Line of Business
Section 12	Prohibited Rating Factors
Section 13	Incorporated Materials
Section 14	Severability
Section 15	Enforcement
Section 16	Effective Date
Section 17	History

**Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-107 and 10-16-109, C.R.S. (2012).

**Section 2      Scope and Purpose**

The purpose of this regulation is to establish and implement rules for setting premiums for grandfathered individual, small group and large group plans. Article 16, as it existed prior to the effective date of HB 13-1266, applies to grandfathered health benefit plans, unless grandfathered health benefit plans are specifically addressed in Article 16 as amended by House Bill 13-1266.

**Section 3      Applicability**

This regulation shall apply to all carriers that have grandfathered individual, small group, large group health benefit plans, and/or student health insurance plans, in Colorado. This regulation concerns grandfathered individual, small and large group health benefit plans, to include student health coverage.

**Section 4      Definitions**

- A. "Administrative ratio" means, for purposes of this regulation, the ratio of actual total administrative expenses, not including policyholder dividends, to the value of the actual earned premiums, not reduced by policyholder dividends, over the specified period, which is typically a calendar year.
- B. "Benefits ratio" shall have the same meaning as found at § 10-16-102(5.3), C.R.S. (2012). Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits ratio calculations must be displayed without the inclusion of active life reserves.
- C. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S. (2012).
- D. "Covered lives" means, for purposes of this regulation, the number of members, subscribers and dependents.

- E. "Dividends" means, for purposes of this regulation, both policyholder and stockholder dividends.
- F. "Excessive rates" means, for purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided or if the rates include a provision for expenses that is unreasonably high in relation to the services rendered. In determining if the rate is excessive, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of whatever relevant information the Commissioner deems necessary in determining whether to approve or disapprove a rate filing.
- G. "Filed rate" means, for purposes of this regulation, the index rate as adjusted for plan design and the case characteristics of age, geographic location, and family size only. The "filed rate" does not include the index rate as further adjusted for any other case characteristic (See Section 7.A. of this regulation).
- H. "File and use" means, for purposes of this regulation, a filing procedure that requires rates and rating data to be filed with the Division of Insurance (Division) concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates. Under no circumstance shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date. Carriers may bill members but not require the member remit premium prior to the proposed implementation date of the rate change.
- I. "Filing date" means, for purposes of this regulation, the date that the rate filing is received at the Division.
- J. "Grandfathered plan" means, for purposes of this regulation, a health benefit plan provided to an individual, employer, or other group by a carrier on or before March 23, 2010, for as long as it maintains that status in accordance with federal law, and includes an extension of coverage under an individual or employer health benefit plan that existed before March 23, 2010, to a dependent of an individual enrolled in the plan or to a new employee and his or her dependents who enroll in the employer health benefit plan.
- K. "Health benefit plan" shall have the same meaning as found at § 10-16-102(21), C.R.S. (2012).
- L. "Implementation date" means, for purposes of this regulation, the date that the filed or approved rates can be charged to an individual or group.
- M. "Inadequate rates" means, for purposes of this regulation, rates that are clearly insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of whatever relevant information the Commissioner deems necessary in determining whether to approve or disapprove a rate filing.
- N. "Lifetime loss ratio" means, for the purposes of this regulation:
  - 1. A ratio equal to:



- a. The sum of the accumulated value of policy benefits from the inception of the policy form(s) to the end of the experience period and the present value of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage; divided by:
  - b. The sum of the accumulated value of earned premiums from the inception of the policy form(s) to the end of the experience period and the present value of expected earned premium over the entire future period for which the proposed rates are expected to provide coverage.
- 2. The lifetime loss ratio should be calculated on an incurred basis as the ratio of accumulated and expected future incurred losses to accumulated and expected future earned premiums. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits or loss ratio calculations must be displayed without the inclusion of active life reserves.
- 3. An appropriate rate of interest should be used in calculating the accumulated values and the present values of incurred losses and earned premiums.
- 4. Any policy form or forms for which the benefits ratio in any policy duration is expected to differ more than 10% from the lifetime loss ratio shall be assumed to have been priced on a "lifetime loss ratio standard", for purposes of this regulation.
- O. "Metropolitan statistical area" or "MSA" means, for purposes of this regulation, a relatively freestanding area of the state determined by one or more large population nuclei, together with adjacent communities, that have a high degree of economic and social integration with the nuclei. Each MSA is not closely associated with another MSA. An MSA is a statistical standard developed for use by the Federal Office of Management and Budget, following a set of officially published standards, including, but not limited to, the acceptable underlying population base.
- P. "On-rate-level premium" means, for purposes of this regulation, the premium that would have been generated if the present rates had been in effect during the entire period under consideration.
- Q. "Plan" means, for purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.
- R. "Premium" means, for purposes of this regulation, the amount of money paid by the insured member, subscriber, or policyholder as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier's expectation of the insured's future claim costs and the insured's share of the carrier's claims settlement, operational and administrative expenses, and the carrier's cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract
- S. "Primary metropolitan statistical area" or "PMSA" means, for purposes of this regulation, a possible subcategory of an MSA, which has a million or more persons living in that MSA. The PMSA consists of a large urbanized county or cluster of counties that demonstrate very strong internal economic and social links, in addition to close ties, to other portions of the larger area. Each PMSA is also determined by the Federal Office of Management and Budget following a set of officially published standards, including, but not limited to, the acceptable underlying population base.

- T. "Prior approval" means, for purposes of this regulation, a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to agents, collections of premium, or any other use of the rate. Under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing. After the rate filing has been approved by the Commissioner, carriers may bill members but not require the member remit premium prior to the proposed implementation date of the rate change.
- U. "Product(s)" means, for purposes of this regulation, the services covered as a package under a policy form by a carrier, which may have several cost-sharing options and riders as options.
- V. "Qualified actuary" means, for purposes of this regulation, an actuary who meets the requirements of Colorado Insurance Regulation 1-1-1.
- W. "Rate" means, for purposes of this regulation, the amount of money a carrier charges as a condition of providing health care coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs, and the insured's share of the carrier's claim settlement, operational and administrative expenses, and cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.
- X. "Rate filing" means, for purposes of this regulation, a filing that contains all of the items required in this regulation, and
1. For individual products, the proposed base rates and all rating factors, the underlying rating assumptions, and support for changes in these rates, factors and assumptions; and
  2. For group products, the underlying rating factors and assumptions, and support for changes in these factors and assumptions.
- Y. "Rate increase" shall have the same meaning as found at § 10-16-102(36.5), C.R.S. (2012).
- Z. "Rating period" shall have the same meaning as found at § 10-16-102(38), C.R.S. (2012).
- AA. "Renewed" means, for the purposes of this regulation, a health benefit plan renewed upon the occurrence of the earliest of: the annual anniversary date of issue; the date on which premium rates can be or are changed according to the terms of the plan; or, the date on which benefits can be or are changed according to the terms of the plan. If the health benefit plan specifically allows for a change in premiums or benefits due to changes in state or federal requirements and a change in the health benefit plan premiums or benefits that is solely due to changes in state or federal requirements is not considered a renewal in the health care coverage contract, then such a change will not be considered a renewal for the purposes of this regulation.
- AB. "Retention" means, for the purposes of this regulation, the sum of all non-claim expenses including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses as percentage of total premium (or 100% minus the lifetime loss ratio, for products priced on a lifetime loss ratio standard).
- AC. "SERFF" means, for the purposes of this regulation, System for Electronic Rate and Form Filings.

- AD. "Student health insurance coverage" means, for the purpose of this regulation, a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education that does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education, or does not condition eligibility for health insurance coverage on any health-status-related factor related to a student or a dependent of a student.
- AE. "Trend" or "trending" means, for purposes of this regulation, any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing.
- AF. "Trend factors" means, for purposes of this regulation, rates or rating factors which vary over time or due to the duration that the insured has been covered under the policy or certificate, and that reflect any of the components of medical or insurance trend assumptions used in pricing. Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and technology. Insurance trend includes the effect of underwriting wear-off, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Underwriting wear-off means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wear-off does not apply to guaranteed issue products. Trend factors include inflation and durational factors.
- AG. "Unfairly discriminatory rates" means, for purposes of this regulation, charging different rates for the same benefits provided to individuals, or groups, with like expectations of loss; and/or, if after allowing for practical limitations, differences in rates fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.
- AH. "Use of the rates" means, for purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder. It does not include releasing information about the proposed rating change to other government entities or disclosing general information about the rate change to the public.
- AI. "Wellness and prevention program" shall have the same meaning as found at § 10-16-136(7)(b), C.R.S.(2012).

## **Section 5 Requirements to Maintain Grandfathered Status and Recordkeeping**

- A. A carrier must retain in its files all necessary documentation to support its determination that a policyholder's plan is grandfathered. The information must be sufficient to demonstrate that the carrier's determination of grandfathered status as determined by the requirements of 45 C.F.R. §147.140, is credible.
- B. A carrier's documentation supporting the grandfathered plan designation must be made available to the Commissioner or the U.S. Department of Health and Human Services for review and examination upon request, and retained for a period of not less than ten (10) years. For each plan, the records supporting the carrier's determination must also be made available to participants and beneficiaries upon request.

- C. A carrier's documentation must establish for each grandfathered plan that since March 23, 2010:
1. The plan was not amended to eliminate all or substantially all the benefits to diagnose or treat a particular condition. A list of all plan benefit amendments that eliminate benefits and the date of the amendment is the minimum level of acceptable documentation that must be available to support this criteria;
  2. The cost-sharing percentage requirements for the plan, if applicable, were not increased after March 23, 2010. A list of each cost-sharing percentage that has been in place for a grandfathered plan, beginning with the cost-sharing percentage on March 23, 2010, is the minimum level of acceptable documentation that must be available to support this criteria;
  3. The fixed cost-sharing requirements other than copayments did not increase by a total percentage measured from March 23, 2010 to the date of change that is more than the sum of medical inflation plus fifteen percent (15%). A list of the fixed cost-sharing requirements other than copayments that apply to a grandfathered plan beginning on March 23, 2010, and a record of any increase, the date and the amount of the increase, is the minimum level of documentation that must be available to support this criteria;
  4. Copayments did not increase by an amount that exceeds the greater of:
    - a. A total percentage measured from March 23, 2010 to the date of change that is more than the sum of medical inflation plus fifteen percent (15%); or
    - b. Five dollars (\$5.00), adjusted annually for medical inflation measured from March 23, 2010. A record of all copayments beginning on March 23, 2010 applicable to a grandfathered plan, and any changes in the copayment since that date is the minimum level of documentation that must be available to support this criterion.
  5. The employer's contribution rate toward any tier of coverage for any class of similarly situated individuals did not decrease by more than five percent (5%) below the contribution rate in place on March 23, 2010, expressed as a percentage of the total cost of coverage. The total cost of coverage must be determined using the methodology for determining applicable COBRA premiums. If the employer's contribution rate is based on a formula such as hours worked, a decrease of more than five percent (5%) in the employer's contributions under the formula will cause the plan to lose grandfathered status. The carrier must retain a record of the employer's contribution rate for each tier of coverage, and any changes in that contribution rate, beginning March 23, 2010 as the minimum level of documentation that must be available to support this criteria;
  6. On or after March 23, 2010, the plan was not amended to impose an overall annual limit on the dollar value of benefits that was not in the applicable plan documents on March 23, 2010;
  7. On or after March 23, 2010, the plan was not amended to adopt an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit for all benefits that was in effect on March 23, 2010; and
  8. The plan was not amended to decrease the dollar value of the annual limit, regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits.

- D. In addition to documentation establishing that none of the prohibited changes described in subsection C. of this section have occurred, a carrier must also make available to the Commissioner upon request the following information for each grandfathered plan:
1. Enrollment records of new employees and members added to the plan on or after March 23, 2010;
  2. Underwriting rules and guidelines applied to enrollees on or after March 23, 2010; and
  3. Proof of notification to the individual or group of its plan's grandfathered status designation for each year for which the status is claimed.
- E. A change to a plan, adopted pursuant to a legally binding contract, state insurance department filing or written plan amendment on or before March 23, 2010, but that became effective after March 23, 2010, is permitted without negating a plan's grandfathered status. If the plan change resulted from a merger, acquisition or similar business action where one of the principal purposes is covering new individuals from the merged or acquired group under a grandfathered health plan, the plan may not be designated as grandfathered.
- F. A carrier may delegate the administrative functions related to documenting or determining grandfathered status designation to a third party. Such delegation does not relieve the carrier of its obligation to ensure that the designation is correctly made, that replacement plans are issued in a timely and compliant manner as required by state or federal law, and that all requisite documentation is kept by the carrier.
- G. If the Commissioner determines that a carrier incorrectly designated a group plan as grandfathered, the plan is non-grandfathered, and must be discontinued and replaced with a plan that complies with all relevant market requirements within thirty (30) days. This section does not preclude additional enforcement action.
- H. A carrier must designate whether a plan is grandfathered or non-grandfathered as required by the Colorado State SERFF filing instructions.

## **Section 6      General Rate Filing Requirements**

All grandfathered individual, small group, and large group health benefit rate filings must be filed electronically in a format made available by the Division, unless exempted by rule for an emergency situation as determined by the Commissioner. Failure to supply the information required in Sections 6, 7, 8 and 11, as applicable, of this regulation will render the filing incomplete. Incomplete filings are not reviewed for substantive content. If the carrier fails to comply with these requirements, the carrier will be notified that the filing has been returned as incomplete. Complete filings will have all the relevant general requirements, rate and policy forms information filled out in the electronically submitted rate filing. If a filing is returned due to lack of completeness, the rates may not be used or distributed. All filings that are not returned or disapproved on or before the 30th calendar day after receipt will be considered complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be identified and communicated to the filing carrier on or before the 45th calendar day after receipt. Correction of any rate filing deficiency, including deficiencies identified after the 45th calendar day, will be required on a prospective basis, and no penalty will be applied for a non-willful violation identified in this manner. Nothing in this regulation shall render a rate filing subject to prior approval by the Commissioner that is not otherwise subject to prior approval as provided by statute.

**A. General Requirements**

1. Prior Approval: Any proposed rate increase is subject to prior approval by the Commissioner and must be filed with the Division at least sixty (60) calendar days prior to the proposed implementation or use of the rates.
  - a. If the Commissioner approves the rate filing within sixty (60) calendar days after the filing date, the carrier may use the rates immediately upon approval; however, under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing.
  - b. A carrier who provides insurance coverage under the rates before the proposed implementation date will be considered as using unfiled rates and the Division will take appropriate action as defined by Colorado law.
  - c. After the rate filing has been approved by the Commissioner, carriers may bill members but not require the member remit premium prior to the proposed implementation date of the rate change.
  - d. If the Commissioner does not approve or disapprove the rate filing within sixty (60) calendar days after the filing date, the carrier may implement and make use of the rates.
  - e. Under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing.
2. Existing law also defines a rate increase to be an increase in the current rate. Any rate filing that would include increasing any base rate or rating factor used to calculate premium rates that results in an overall increase in the current rate to any existing policyholder or certificate holder renewing during the proposed rating period of the filing would be considered a prior approval filing.

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

The Commissioner may require the submission of whatever relevant information the Commissioner deems necessary in determining whether to approve or disapprove a rate filing. Corrections of any deficiency identified after the 60th calendar day will be required on a prospective basis and no penalty will be applied for a non-willful violation identified in this manner if the rates are determined to be excessive, inadequate or unfairly discriminatory. All filings must be filed with the Rates and Forms Section of the Division. The Commissioner shall disapprove the rate filing if any of the following apply:

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

- b. The rate filing contains rates that are excessive, inadequate, unfairly discriminatory, or otherwise does not comply with the provisions of Sections 6, 7, 8, 9, 10 and 11, as applicable, of this regulation. In determining if the rate is excessive or inadequate, the Commissioner may consider profits, dividends, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice;
  - c. The actuarial reasons and data do not justify the requested rate increase; or
  - d. The rate filing is incomplete.
- 3. **File and Use:** Any rate filing not specified in paragraph 1. of this subsection is classified as file and use. Existing law allows for file and use rate filings to be implemented upon submission to the Division and correction of any deficiency shall be on a prospective basis. All filings not returned on or before the 30th day after receipt will be considered complete.

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

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

- 4. **Required Submissions:**
  - a. All carriers must submit a compliant rate filing whenever the rates charged to renewing policyholders, or certificate holders differ from the rates on file with the Division. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in trend or other rating assumptions. Failure to file a rate filing that is compliant with this regulation in these instances will render the carrier as using unfiled rates and the Division will take appropriate action as allowed by Colorado law.
  - b. All carriers must submit a compliant rate filing on an annual basis, at minimum, to support the continued use of trend factors, which change on a predetermined basis. The rate filing must contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate. The rate filing shall contain all of the items required in this regulation. The rate filing must demonstrate that the rate is not excessive, inadequate or unfairly discriminatory. Note: Trend factors which change on a predetermined basis can be continued for no more than twelve (12) months. To continue the use of trend factors that change on a predetermined basis, a filing must be made for that particular form with an implementation or effective date on or before the one-year anniversary of the implementation or effective date of the most recent rate filing for that form.

- c. All carriers must submit a rate filing within sixty (60) calendar days after Commissioner approval of the assumption or acquisition of a block of business. This rate filing should provide detailed support for the rating factors the assuming or acquiring carrier proposes to use, even if the rating factors are not changing. The new filing must demonstrate that the rating assumptions continue to be appropriate.
  - d. Each line of business requires a separate rate filing. Rate filings should not be combined with form filings.
  - e. All carriers are expected to review their experience on a regular basis, no less than annually, and file rate revisions, as appropriate, in a timely manner to ensure that rates are not excessive, inadequate or unfairly discriminatory, and to avoid filing large rate changes.
  - f. The Form Schedule tab in SERFF must be completed for all rate and form filings. This tab must list policies, riders, endorsements, or certificates referenced in the rate filing. Do not attach the actual forms to a rate filing.
- 5. Withdrawn, Returned, or Disapproved Filings: Filings that have either been withdrawn by the filer, returned by the Division as incomplete or disapproved as unjustified, and subsequently are resubmitted, will be considered as new filings. If a filing is withdrawn, returned, or disapproved, the rates may not be used or distributed. Nothing in this regulation shall render a rate filing subject to prior approval by the Commissioner that is not otherwise subject to prior approval as provided by statute.
- 6. Carrier Specific: A separate filing must be submitted for each carrier. A single filing, which is made for more than one carrier or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan.
- 7. Submission of Rate Filings: All grandfathered individual and large group health benefit plan rate filings must be filed electronically in a format made available by the Division, unless exempted by rule for an emergency situation as determined by the Commissioner. If the carrier fails to comply with these requirements, the carrier will be notified that the filing has been returned as incomplete. Complete filings will have all the relevant general requirements, rate and policy forms information filled out in the electronically submitted rate filing. If a filing is returned due to lack of completeness, the rates may not be used or distributed.
- 8. Required Inclusions: Rate filings require the submission of an actuarial memorandum in the format specified in Section 7 of this regulation. A response must be provided for each element contained in Section 7. The level of detail and the degree of consistency incorporated in the experience records of the carrier are vital factors in the presentation and review of rate filings. Every rate filing shall be accompanied by sufficient information to support the reasonableness of the rate. Valid carrier experience should be used to justify grandfathered plans. Actual Colorado experience must be submitted with changes to existing products. In addition, the Commissioner may request additional information used by the carrier to support the rate change request.



9. Confidentiality: All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. The Division does not consider such items as rates, rating factors, rate histories, or side-by-side comparisons of rates or retention components to be confidential. The entire filing, including the actuarial memorandum, cannot be held as confidential. There should be separate SERFF component for the confidential exhibits, and must be indicated by the icon as confidential in SERFF. Non-confidential information, such as the actuarial memorandum, must be in a separate SERFF component.
10. A "Confidentiality Index" must be completed if the carrier desires confidential treatment of any information submitted, as required in this regulation. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected. It should be noted that HMOs are not afforded automatic confidential treatment of any rate filings; and, therefore, must complete a Confidentiality Index.

**B. Actuarial Certification**

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

**C. Wellness and prevention programs: A carrier offering individual and/or small group health coverage in this state may offer incentives or rewards to encourage the individual and other covered persons under the plan to participate in wellness and prevention programs, pursuant to § 10-16-136, C.R.S.(2012), and shall be subject to the following:**

1. The incentives or rewards shall be made to all participants in the program and may include, but are not limited to: premium discounts or rebates; modifications to copayment, deductible, or coinsurance amounts; the absence of a surcharge; the value of a benefit that would otherwise not be provided; or, a combination of these incentives or rewards.
2. The program shall be voluntary and a penalty shall not be imposed on a covered person for not participating.
3. The carrier shall not use the wellness and prevention programs, or incentives or rewards under such programs, to increase rates or premiums for any individuals covered by the carrier's plans.
4. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:
  - a. Does not shift costs to individuals that decline to participate in the program; and
  - b. Is reasonably related to the program.
5. For wellness and prevention programs providing incentives or reward which are based upon satisfaction of a standard related to a health risk factor:
  - a. The carrier shall provide in each filing proof that the wellness program has been accredited by a nationally recognized nonprofit entity that accredits wellness programs pursuant to § 10-16-136(3.7), C.R.S.;
  - b. The carrier shall document that the wellness program is scientifically proven to improve health and that the incentives are not provided based on an individual's actual health status; and

- c. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:
    - (1) Does not exceed 20% of the premium; and
    - (2) Is not a subterfuge for discriminating based upon a health status-related factor.
- 6. The carrier shall include any information as required by the Commissioner to ensure that the filed rates, in conjunction with the incentives and rewards available under the wellness program, are not excessive, inadequate, or unfairly discriminatory.

## **Section 7      Actuarial Memorandum**

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

- A. Summary: A brief written summary of the filing including, but not limited to, the following:
  - 1. Reason(s) for the rate filing: A statement that this is a rate revision and the reason for the revision shall be included.
  - 2. Requested Rate Action: The overall rate increase or decrease should be listed. The listed rate change, the average change in each rate component and the change in renewal date by effective month must be provided. The submission must also list the twelve (12) month renewal with changes by component and the averages by component.
  - 3. Marketing Method(s): A brief description of the marketing method used for the filed form should be listed. (Agency/Broker, Internet, Direct Response, Other)
  - 4. Premium classification: The section should state all attributes upon which the premium rates vary.
  - 5. Product descriptions: This section should describe the benefits provided by the policy.
  - 6. Policy/Rider or Contract: This section must include a listing of all policies/riders or contracts impacted by the submission.
  - 7. Age basis: A statement as to whether the premiums will be charged on an issue age, attained age, renewal age or other basis and the issue age range of the form, as applicable, should be specified.
  - 8. Renewability provision: All health plans are guaranteed renewable.

- B. **Assumption or Acquisition:** The memorandum must state whether or not the products included in the rate filing are part of an assumption or acquisition of policies from/with another carrier. If so, the memorandum must include the full name of the carrier/carriers from which the policies were assumed, acquired or merged, and the effective date of the assumption or acquisition, and the SERFF Tracking Number of the assumption of the acquisition, or assumption rate filing. Commissioner approval of the assumption or acquisition of a block of business is required. See Section 6.A.4.c. for acquisition or assumption rate filing requirements.
- C. **Rating Period:** The memorandum must identify the period for which the rates will be effective. At a minimum, the proposed implementation date of the rates must be provided. If the length of the rating period is not clearly identified, it will be assumed to be for twelve (12) months, starting from the proposed implementation date.
- D. **Effect of Law Changes:** The memorandum should identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in law(s) or regulation(s), including federal, state or local. All applicable benefit mandates should be listed, including those with no rating impact. This quantification must include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.
- E. **Rate History:** The memorandum must include a chart showing the rate changes implemented including the implementation date of each rate change in at least the three (3) years immediately prior to the date of the filing. This chart must contain the following information: the filing number (State or SERFF tracking number), the implementation date of each rate change, average increase or decrease, minimum and maximum increase and cumulative rate change for the past twelve (12) months. The cumulative effect of all rate filings, submitted in the prior year, on renewal rates should be specified. The rate history should be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.
- F. **Coordination of Benefits:** Each rate filing must reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.
- G. **Relation of Benefits to Premium:** The memorandum must adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period. This relationship will be presumed to be reasonable if the carrier complies with the following:
  - 1. **Retention Percentage:** The actuarial memorandum must list and adequately support each specific component of the retention percentage. The support for a health benefit plan must include a comparison of the most recent levels experienced for each component as shown in the carrier's financial statements, with an explanation for any variations between retention loads used and actual experience for each component.
    - a. If the product was not initially priced using a lifetime loss ratio standard, the retention percentage is equal to the sum of all non-claim components of the rate including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses.
    - b. Each of these specific components must be expressed as a percentage of the earned premium, and should sum to the total carrier retention percentage. Each component should reflect the average assumption used in pricing. Ranges for each assumption and flat dollar amounts are not permitted. The component for profit/contingencies should reflect the target load for profit and contingencies, and not the expected results or operating margin.

The Commissioner will evaluate each component for reasonableness and consistency with other similar rate filings. Any change in these components from the previous rate filing must be adequately supported. It should be noted that broad groupings of these components are not permitted.

2. Benefits Ratio Guidelines: The Commissioner uses these percentages as guidelines for the acceptability of the carrier's targeted benefits ratio.

- a. All rate filings justifying the relationship of benefits to premium using one of these guidelines must list the components of the retention percentage, as defined in Subsection G.1. of this section. The Commissioner will evaluate these components for reasonableness. Policy forms priced at, or above, these benefits ratios may be unacceptable, if one or more of the retention components is not supported.
- b. The Division recommended benefits ratio guidelines are as listed below. Targeted benefits ratios below these guidelines shall be actuarially justified.

**Benefits Ratio Guidelines**

Comprehensive Major Medical (Individual)	80%
Comprehensive Major Medical (Small Group)	80%
Comprehensive Major Medical (Large Group)	85%
Student Health Insurance Coverage	80%

- c. The benefits ratio guideline for conversion products shall be at least 125%. Adequate support shall be submitted if the benefits ratio is below the 125% guideline.
- d. For individual products issued to HIPAA eligible individuals the premiums for these products are, at most, two times the premiums for the underlying, underwritten product.
- H. Lifetime Loss Ratio for Individual Health Benefit Plans: The memorandum must state whether or not the product was priced initially using a lifetime loss ratio standard. If the product was priced using a lifetime loss ratio standard, then any subsequent rate change request must be based on the same lifetime loss ratio standard unless there has been a material change in assumptions used to price the product including changes in regulations covering the product. Changes to the lifetime loss ratio must be identified and clearly supported. The lifetime loss ratio standard shall consider the effects of investment income. Any subsequent rate change request shall consider the variance in the expected benefits ratios over the duration of the policy. The rate filing must include the average policy duration in years as of the endpoint of the experience period and the expected benefits ratio, as originally priced, for each year of the experience period. The rate filing must also include a chart showing actual and expected benefits ratios for both the experience and rating periods. For each year of the experience period the chart must show the actual and expected benefits ratios, and the ratio of these two (2) benefits ratios. For each year of the rating period, the chart must show the projected and expected benefits ratios, and the ratio of these two (2) benefits ratios. It is expected that the carrier is pricing these products to achieve a benefits ratio greater than or equal to the expected benefits ratio for the rating period.
- I. Provision for Profit and Contingencies. The memorandum must identify the provision percentage for profit and contingencies, and how this provision is included in the final rate. Material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process. Detailed support must be provided for any proposed load.

- J. Complete Explanation as to How the Proposed Rates were Determined: The memorandum must contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if adequate support for each rating assumption is not provided. This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis, but must completely explain how the proposed rates were determined. The memorandum must adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.
- K. Trend: The memorandum must describe the trend factor assumptions used in pricing. These trend factor assumptions must each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported. Trend factors do not renew automatically. Continued use of trend factors must be supported annually. This must be provided in an Excel spreadsheet.
1. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be provided if available. This experience may include data from the plan being rated, or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.
  2. Provided loss data must be on an incurred basis, with pharmacy data shown separately from medical data, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and "incurred but not reported" (IBNR) reserves) as of the valuation date. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.
  3. The provided claims experience shall include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims; total medical incurred claims (including estimated IBNR claims); actual pharmacy paid on incurred claims; total pharmacy incurred claims (including estimated IBNR claims); average covered lives for medical; and, average covered lives for pharmacy.
  4. Data elements shall be aggregated into 12-month annual periods, with yearly "per member, per month" (PMPM) data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified. The trend assumptions shall be quantified into two (2) categories, medical and insurance, as defined below:
    - a. Medical trend means, for the purposes of this section, the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology.
    - b. Insurance trend means, for the purposes of this section, the combined effect of underwriting wear-off, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Note: medical trend must be determined or assumed before insurance trend can be determined. Underwriting wear-off means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wear-off does not apply to guaranteed issue products.

Major service categories are Hospital Inpatient, Outpatient, Physician, Pharmacy, Other.

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- L. Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three (3) years, if the proposed rates are based on claims experience.
1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and applicability of the use of such data must be discussed. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is  $\text{SQRT} [(\# \text{ life years or claims}) / \text{full credibility standard}]$ . The full credibility standard is defined above. Colorado data must still be provided.
  2. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.
- M. Data Requirements: The memorandum must include, at a minimum, earned premium data, loss experience data, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. This must be provided in an Excel spreadsheet.
1. Pharmacy claims data should be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.
  2. National or other relevant data shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates, rating factors, rating methodology and trend.
  3. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used for support rates must be included in the filing. For renewal filings, the experience period must include consecutive data no older than six (6) months prior to the filing (submission) date. For renewal filings the experience period must include consecutive data no older than nine months prior to the rate effective implementation date.
  4. The loss data must be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Premiums, and/or exposure data, must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information on how the number of claims was calculated.
- N. Side-by-Side Comparison: Each memorandum must include a “side-by-side comparison” identifying any proposed change(s) in rates. This comparison should include three columns: the first containing the current rate, rating factor, or rating variable; the second containing the proposed rate, rating factor, or rating variable; and the third containing the percentage increase or decrease of each proposed change(s).

- O. **Benefits Ratio Projections:** The memorandum must contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison should be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should be included. This must be provided in an Excel spreadsheet.
- P. **Other factors:** The memorandum must clearly display or clearly reference all other rating factors and definitions used, including the area factors, age factors, etc., and provide support for the use of each of these factors in the new rate filing. The same level of support for changes to any of these factors must be included in all renewal rate filings. In addition, the Commissioner expects each carrier to review each of these rating factors every five (5) years, at minimum, and provide detailed support for the continued use of each of these factors in a rate filing. This must be provided in an Excel spreadsheet.

## **Section 8      Premium Rate Setting for Small Group Health Benefit Plans**

- A. **Calculating Premium Rates Adjusted for Case Characteristics**
1. **Index Rate:** Each carrier offering a health benefit plan to small employers in Colorado shall develop a single index rate for all small group plans it offers. This single index rate is identical to a community rate for the carrier's universe of small group plans offered for renewal. It should be calculated using the experience for all small group plans. The premium rate charged during a rating period, applicable to all small employers, shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this Section 8.
  2. **Plan Design Adjustment:** The index rate may be adjusted to reflect differences attributable to different plan designs. If the carrier elects to make this adjustment, the carrier should calculate a rate adjustment factor for each small group plan design. Differences in the rates for different benefit plans, for persons with the same case characteristics of age, geographic location and family size, shall be attributable to plan design only.
  3. **Acceptable Case Characteristic Factor Categories:** For all small employer policies, carriers choosing to modify the unique index rate by the use of case characteristics must utilize one or more of the categories listed below. Carriers shall develop a rating factor for each category, which is actuarially based.
    - a. **Age:** If a carrier uses age to calculate rates, then it shall use the following twelve (12) mandatory age categories. Rates must be based on employee age only, not employee and spouse ages.

<b>Mandatory Age Categories</b>
Children ages newborn through age 19 (or through age 24 if the child is a full-time student covered as a dependent), excluding emancipated minors
Emancipated minors and persons ages 20 through 24
Age 25 through 29
Age 30 through 34
Age 35 through 39
Age 40 through 44
Age 45 through 49
Age 50 through 54
Age 55 through 59

Age 60 through 64
Age 65 and older: Medicare is primary payer
Age 65 and older: Medicare is secondary payer

- b. Geographic Location: If a carrier uses geographic location to calculate rates, then it shall use the nine (9) mandatory categories listed below. In determining that these geographic location categories best serve the public interest, the Commissioner considered the key issues of accessibility, availability, consumer choice and the cost of health care in all areas of the state. Public and consumer input was solicited, received, and evaluated. The Commissioner determined that these area groupings best serve the public interest by maximizing consumer choice options and health care availability in all areas of the state at the lowest possible cost and will ensure that the rates charged are not excessive, inadequate or unfairly discriminatory. The appropriate population base for these categories is the base as determined by the federal government in establishing MSAs, except for the last two categories listed below. No MSA exists for these counties and consequently, these counties were grouped by population size. Carriers may, with the prior written approval of the Commissioner, establish one (1) or more additional categories by further subdividing the last two (2) categories.

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

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

PMSA = Primary Metropolitan Statistical Area

MSA = Metropolitan Statistical Area



- (1) Geographic rating factors must be determined on the same basis, reflect the relative differences in expected costs, and produce rates that are not excessive, inadequate, or unfairly discriminatory in such geographic areas. For example, a geographic factor of 1.2 for the Colorado Springs MSA and a factor of 1.0 for the Denver MSA would imply that costs can reasonably be expected to be 20% higher in the Colorado Springs MSA than they are in the Denver MSA. All changes in the geographic rating factors must be supported on this basis.
  - (2) Approval to subdivide categories eight and nine above into two (2) or more subcategories must be obtained in advance. The material provided to support the subdivision(s) shall be based upon statistically-credible data using the Division of Insurance's credibility standard and/or other actuarially-determined standards. The Division's credibility standard is 2,000 life-years and 2,000 claims per year. (See Section 7.L. of this regulation).
- c. Family Size: If a carrier uses family size to calculate rates, then it shall use the four (4) mandatory categories listed below. If age is also used as a rating factor, rates must be based on employee age only, not employee and spouse ages.

<b>Mandatory Family Size Categories</b>
1 Adult
2 Adults
1 Adult plus any number of children who are dependents of the primary insured or for whom the primary insured is legally required to provide health insurance coverage.
2 Adults plus any number of children who are dependents of the primary insured or for whom the primary insured is legally required to provide health insurance coverage.

- d. Tobacco Use: If a carrier reflects tobacco usage in the calculation of rates, then it must do so according to the following requirements found at § 10-16-105(8.5)(a)(I)(B), C.R.S. (2012):
- (1) The carrier shall provide a wellness and prevention program;
  - (2) Any individual who participates in the program shall be given the lower rate;
  - (3) Any rate adjustment attributable to an individual (and all similarly situated individuals) based upon tobacco usage shall be applied to that individual (and all similarly situated individuals), and shall not be distributed to the entire group; and
  - (4) The carrier shall use one of the following two (2) allowable rate adjustments:
    - (a) An increase of up to fifteen percent (15%) for tobacco use; or
    - (b) A decrease of up to fifteen percent (15%) for nonuse of tobacco.
    - (c) A discount of up to ten percent (10%) for refraining from smoking for more than twelve (12) consecutive months prior to the effective date or renewal date of the small group policy, pursuant to § 10-16-105(13)(c), C.R.S. (2012).

- e. Standard Industrial Classifications: If the carrier uses the standard industrial classifications pursuant to § 10-16-105(8.5)(a)(I)(A), C.R.S. (2012) to calculate rates, only one (1) factor is permitted for each small group. No enrolled employee should be charged directly for any such adjustment.
    - f. All rating adjustments due to the application of any of these case characteristics must be applied consistently in the calculation of all small employers' rates. Any adjustments made due to standard industrial classification should be applied uniformly to the rates charged for all employees enrolled under each small group policy.
    - g. All rate filings must contain adequate and acceptable detail information as to how the rating factors used for tobacco use is determined and the combined maximum and minimum effect of applying the rating factor.
    - f. Health status and claims experience may not be used as case characteristics. A health questionnaire, requesting reasonable information, may be used to obtain information about the health status of group enrollees. However, the health questionnaire may not be used in any way to determine the premium rate or any rating factor that is used in the determination of the premium rate that is charged to the group, except as provided in subparagraph d. of this paragraph.
  - 4. Wellness and Prevention Programs: A carrier may make available wellness and prevention programs as provided for under Section 6.C. of this regulation.
- B. Rating Period

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

- 1. A carrier specifies in its rate filings a different rating period, which shall be the same for all its small group health benefit plans issued or renewed in the same calendar month; and
- 2. The carrier clearly disclosed in all its small employer solicitation and sales materials exactly what the different rating period was.

C. Administrative and Other Fees

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

**Section 9 Use of Composite Rates for Small Group Health Benefit Plans**

- A. Carriers may offer the small employer rates calculated by use of the following methods subject to the following restrictions:
- 1. Four-tier family, age-banded rates calculated pursuant to Section 8 of this regulation; or
  - 2. A choice between four-tier, age-banded rates, calculated pursuant to Section 8 of this regulation, and composite rates. It shall be construed that the carrier has offered the small employer a choice between the two (2) methods if, at initial application and at each renewal:

- a. Both methods are offered to the small employer, with the differences clearly explained in writing; or
  - b. The small employer is given a written option to indicate that:
    - (1) Both rating methods need be presented;
    - (2) Only age-banded rates need be presented; and
    - (3) Only the composite rate need be presented. This indication may be a check-off on the application or renewal form or other similar form that complies with this section.
- B. Carriers may offer small employers composite rates as an alternative to four-tier, age-banded rates calculated pursuant to Section 8 of this regulation if all of the following conditions are met:
  - 1. The carrier makes the same offer across its entire book of Colorado small group business where an employer has ten (10) or more eligible employees. If the carrier makes this offer to all small employers having ten (10) or more eligible employees, then the carrier may also offer composite rates to small employers having fewer than ten (10) eligible employees. The carrier must establish a pre-determined minimum size for offering composite rates. The same offer must be made available to all small employers having at least this pre-determined number of eligible employees.
  - 2. The carrier must clearly state on its application and renewal forms for all of its small group products the differences between age-banded and composite rates and that either:
    - a. The minimum number of eligible employees for calculating composite rates is ten (10) and that all small employers with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates, and have the right to see them calculated either or both ways; or
    - b. If the number of minimum eligible employees is less than ten (10), the carrier shall state the minimum number and that all small employers with at least this minimum number of eligible employees are entitled to a choice of composite rates or four-tier, age-banded rates, and have the right to see them calculated either or both ways.
  - 3. Calculating Composite Rates.

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

4. The carrier uses the same composite rating methodology for all small employers. The carrier may offer composite rates on a two-tier (i.e. employee and employee plus dependents), three-tier or four-tier composition basis. If the carrier elects to offer these three (3) choices, it is at the employer's sole discretion whether the composite rates are set on the two-tier, three-tier, or four-tier family composition basis. However, the basis for the calculation of initial premiums before composite rating for a particular employer must be based on four-tier family, age-banded rates calculated pursuant to Section 8 of this regulation.
  5. At the time of the initial application by the small employer, the composite rating and four-tier family, age-banded rating for a particular small employer must result in identical total premium collections due from that employer for the first month of the rating period. At renewal, the composite rating method and four-tier family, age-banded rating methods for each small employer must result in identical total premium amounts as of the date of the renewal calculation. Assuming there is no change in the demographic composition of the small employer group, composite rating and four-tier family, age-banded rating for a particular employer must result in identical total premium collections due from that employer for a given rating period.
- C. Nothing in this section shall be construed to require carriers to provide other than four-tiered, age-banded rates.

#### **Section 10      Rate Filings for Small Group Health Benefit Plans**

The provisions of § 10-16-107, C.R.S. (2012) and this regulation shall apply to the filing of rates for grandfathered small employer health benefit plans. Expected rate increases for small employer health benefit plans shall be submitted for approval to the Division of Insurance at least sixty (60) calendar days prior to the proposed implementation of the rate.

#### **Section 11      Additional Rate Filing Requirement by Line of Business**

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

- A. Wellness and Prevention Programs: A carrier offering an individual health coverage plan or a small group plan in this state may offer incentives or rewards to encourage the individual or small group and other covered persons under the plan to participate in wellness and prevention programs, pursuant to §10-16-136, C.R.S. (2012), and shall be subject to the following:
1. The incentives or rewards shall be made to all participants in the program and may include, but are not limited to: premium discounts or rebates; modifications to copayment, deductible, or coinsurance amounts; the absence of a surcharge; the value of a benefit that would otherwise not be provided; or, a combination of these incentives or rewards.
  2. Incentives or rewards provided under the program shall not be based upon the size or composition of the small group.
  3. The program shall be voluntary and a penalty shall not be imposed on a covered person or small group for not participating.
  4. The carrier shall not use the wellness and prevention programs, or incentives or rewards under such programs, to increase rates or premiums for any individuals or small groups covered by the carrier's plans.

5. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:
    - a. Does not shift costs to individuals or small groups that decline to participate in the program; and
    - b. Is reasonably related to the program.
  6. For wellness and prevention programs providing incentives or reward which are based upon satisfaction of a standard related to a health risk factor:
    - a. The carrier shall provide in each filing proof that the wellness program has been accredited by a nationally recognized nonprofit entity that accredits wellness programs pursuant to § 10-16-136(3.7), C.R.S. (2012);
    - b. The carrier shall document that the wellness program is scientifically proven to improve health and that the incentives are not provided based on an individual's actual health status; and
    - c. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:
      - (1) Does not exceed 20% of the premium; and
      - (2) Is not a subterfuge for discriminating based upon a health status-related factor.
    - d. For purposes of small group plans, the incentives or rewards attributable to the individual (and all similarly situated individuals) shall be applied to that individual (and all similarly situated individuals), and shall not be distributed to the entire group.
  7. The carrier shall include any information as required by the Commissioner to ensure that the filed rates, in conjunction with the incentives and rewards available under the wellness program, are not excessive, inadequate, or unfairly discriminatory.
- B. Large Group Health Coverage Plans (to include Student Health Insurance Coverage): Large group health coverage plan contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing must contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing should also contain an example of how the large group health rates are calculated. While the final rate charged the large group may differ from the initial quote, all rating variables must be on file with the Division.

Although it is not necessary to submit a separate rate filing for each large group policy issued, each carrier must retain detailed records for each large group policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each group insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate should be identified in the detail material and lie within the range identified in the rate filing on file with the Division. The carrier shall make all such information available for review by the Commissioner upon request. All such requests will be made at least three (3) business days prior to the date of review.

The rates for subgroups must be determined in an actuarially sound manner using credible data. The methodology for determining these rates must be on file with the Division and any changes in the methodology must be filed with the Division.

- C. Valid Multi-State Association Groups: Pursuant to § 10-16-107(6), C.R.S. (2012), any health benefit plan issued before March 10, 2010 for any valid multi-state association under § 10-16-214(2), C.R.S. (2012), shall not use any health status-related factor in determining the premium or contribution for any enrolled individual and/or their dependent. However, the prohibition in this subsection shall not be construed to prevent the carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for adherence to programs of health promotion or disease prevention if otherwise allowed by state or federal law.

## **Section 12 Prohibited Rating Practices**

The Commissioner has determined that certain rating activities lead to excessive, inadequate or unfairly discriminatory rates, and are unfair methods of competition and/or unfair or deceptive acts or practices in the business of insurance. Therefore, in accordance with § 10-16-107, C.R.S. (2012) and § 10-3-1110(1), C.R.S., the following are prohibited:

- A. Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating;
- B. The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income;
- C. For individual health benefit plans, rates shall not vary due to the gender of the individual policyholder, enrollee, subscriber, or member for rates effective on or after January 1, 2011, pursuant to § 10-16-107(1.5)(b), C.R.S. (2012); and
- D. For individual health benefit plans, the use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss. It is the expectation of the Commissioner that areas of the state with like expectations of loss must be treated in a similar manner. Also, policyholders utilizing the same provider groups should be rated in a like manner. The use of zip codes in determining rating factors can result in inequities. Unless different rating factors can be justified based upon different provider groups or other actuarially sound reasons, the following guidelines shall be followed whenever zip codes are used in determining a carrier's rating factors:

1. All zip codes in the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor, with the following possible exceptions:
    - a. The following zip codes in Elbert County: 80101, 80106, 80107, 80117.
    - b. The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136.
    - c. The following zip codes in El Paso County: 80132, 80133.
    - d. The following zip codes in Boulder County: 80025, 80026, 80027, 80028.
  2. In addition, the following zip codes outside the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor as the 800-802 three-digit zip code groups:
    - a. The following zip codes in Jefferson County: 80401-80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465.
    - b. The following zip codes in Adams County: 80614, 80640.
  3. All zip codes in the 809 three-digit zip code group are considered part of the Colorado Springs metropolitan area and shall receive the same rating factor. In addition, the following zip codes in El Paso County, which lie outside the 809 three-digit zip code group shall be considered part of the Colorado Springs metropolitan area and shall receive the same rating factor as the 809 three-digit zip code group: 80809, 80817, 80819, 80829, 80831, 80840, 80841.
- If a carrier uses area rating factors which are based in whole or in part upon the zip code, and does not follow these guidelines, the carrier may be found to have rates that are unfairly discriminatory. The Commissioner would prefer that a carrier use federal MSA's, rather than zip codes, in their rating structure. The Commissioner expects carriers to review the appropriateness of area factors at least every five years and provide detailed support for the continued use of the factors in rate filings and upon request.
- E. For individual health benefit plans, renewal rates shall not be affected by the health status or claims experience of the individual insured. A "claims experience factor," or any other part of the renewal rate calculation, which is based in whole or in part upon the health status or claims experience of the individual insured is prohibited.

### **Section 13      Incorporated Materials**

45 CFR § 147.140 published by the Government Printing Office shall mean 45 CFR § 147.140 as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 147.140. A copy of the 45 CFR § 147.140 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the 45 CFR § 147.140 may be requested from the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at [www.ecfr.gov](http://www.ecfr.gov).

### **Section 14      Severability**

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

**Section 15      Enforcement**

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

**Section 16      Effective Date**

This regulation shall become effective January 1, 2016.

**Section 17      History**

New regulation effective December 1, 2013.  
Amended regulation effective January 1, 2016.

**Regulation 4-2-47      CONCERNING THE REQUIRED BENEFIT FOR APPLIED BEHAVIOR  
ANALYSIS THERAPY FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS FOR A  
CHILD**

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

**Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-104(1.4)(b) and 10-16-109, C.R.S.

**Section 2      Scope and Purpose**

The purpose of this regulation is to establish the requirements for the benefit provided by carriers for applied behavior analysis (ABA) therapy for the treatment of autism spectrum disorders in children.

**Section 3      Applicability**

This regulation shall apply to all carriers offering individual and/or group health benefit plans subject to the individual and group laws of Colorado and the requirements of the Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (ACA). This regulation shall not apply to grandfathered health benefit plans. This regulation replaces Emergency Regulation 13-E-16 in its entirety.

**Section 4      Definitions**

- A. "Applied behavior analysis" or "ABA" shall have the same meaning as found at § 10-16-104(1.4)(a)(I), C.R.S., and § 10-16-104(1.4)(a)(XII)(b), C.R.S.
- B. "Autism services provider" shall have the same meaning as found at § 10-16-104(1.4)(a)(II), C.R.S.



- C. "Autism spectrum disorders" shall have the same meaning as found at § 10-16-104(1.4)(a)(III), C.R.S.
- D. "Grandfathered health benefit plans" shall have the same meaning as found at § 10-16-102(31), C.R.S.
- E. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- F. "Treatment for autism spectrum disorders" shall have the same meaning as found at § 10-16-104(1.4)(a)(XII), C.R.S.

**Section 5 Rules**

- A. All health benefit plans subject to this regulation must provide coverage for the assessment, diagnosis, and treatment of autism spectrum disorders for children.
- B. All health benefit plans subject to this regulation issued or renewed on or after May 15, 2014 must provide coverage for annual ABA therapy to treat autism spectrum disorders in children, which must provide, at a minimum:
  - 1. Five hundred fifty (550) ABA sessions annually for children from birth through age eight (8);
  - 2. One hundred eighty-five (185) ABA sessions annually for children aged nine (9) to nineteen (19);
  - 3. Sessions will be will be calculated in twenty-five (25) minute increments; and
  - 4. Sessions eligible for this benefit must be performed by an autism services provider.
- C. Pursuant to § 10-16-104(1.4)(b)(I), C.R.S., at a minimum, all carriers with health benefit plans subject to this regulation must provide coverage annually for ABA therapy that is equivalent to what was required prior to May 13, 2013.
  - 1. In the event that five hundred fifty (550) annual ABA sessions for a child from birth through age eight (8) does not provide the same coverage for ABA therapy as would have been required prior to May 13, 2013, all carriers with health benefit plans subject to this regulation shall increase the number of visits or sessions in order to provide the equivalent of the minimum number of visits or sessions as would have been required prior to May 13, 2013.
  - 2. In the event that one hundred eighty-five (185) annual ABA sessions for a child aged nine (9) to nineteen (19) does not provide the same coverage for ABA therapy as would have been required prior to May 13, 2013, all carriers with health benefit plans subject to this regulation shall increase the number of visits or sessions in order to provide the equivalent of the minimum number of visits or sessions as would have been required prior to May 13, 2013..
- D. Nothing in this regulation requires or permits a carrier to reduce benefits provided for autism spectrum disorders if a health benefit plan already provides coverage that exceeds the requirements of § 10-16-104(1.4), C.R.S., and this regulation.

**Section 6 Severability**

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

**Section 7 Enforcement**

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

**Section 8 Effective Date**

This regulation shall become effective on May 15, 2014.

**Section 9 History**

Emergency regulation 13-E-15 effective November 1, 2013.  
Emergency regulation 13-E-16 effective December 31, 2013.  
New regulation effective May 15, 2014.

**Regulation 4-2-48 CONCERNING GRACE PERIODS FOR POLICYHOLDERS RECEIVING  
ADVANCE PAYMENT TAX CREDITS**

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

**Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-106.5(8)(b), and 10-16-140(4), C.R.S.

**Section 2 Scope and Purpose**

The purpose of this regulation is to establish the requirements for grace periods for health benefit plans offered on the Exchange for policyholders that receive the federal Advance Payment Tax Credits (APTC), and where the policyholder of the plan is delinquent in the payment of monthly premiums.

**Section 3 Applicability**

The provisions of this regulation shall apply to all individual health benefit plans issued or renewed on or after the effective date of this regulation for policyholders that receive federal Advance Payment Tax Credits. This regulation does not apply to grandfathered health benefit plans.

**Section 4 Definitions**

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

- B. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.
- C. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.
- D. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

**Section 5 Rules**

- A. All individual health benefit plans shall contain a provision that the policyholder is entitled to a three (3) month grace period beginning the first month premium has not been received, as long as the policyholder has previously paid at least one (1) full month's premium during the current benefit year.
- B. During the three (3) month grace period, the health benefit plan shall remain in force, and the carrier:
  - 1. Shall pay all appropriate claims for services rendered to the policyholder during the first month of the grace period; and
  - 2. May pend claims for services rendered to the policyholder during the second and third month of the grace period.
  - 3. If a carrier is unable to pend pharmacy claims during the second and third months of the three (3) month grace period, a carrier may deny those pharmacy claims. The carrier shall be required to reimburse a policyholder directly if a claim is filed for the denied pharmacy benefits once all delinquent premium payments have been received.
  - 4. A carrier must continue to comply with the requirements set forth in §§ 10-16-704(4), 10-16-704(4.5), and 10-16-705(12), C.R.S.
- C. If the policyholder's portion of the premium payment becomes delinquent, the carrier shall provide notice:
  - 1. To the policyholder advising of the premium payment delinquency, including a description of the three (3) month grace period, and that the delinquency applies to all persons covered under the policy;
  - 2. To the policyholder, at least 30 days in advance, of the carrier's intent to terminate coverage due to non-payment of premium in accordance with §§ 10-16-222, 10-16-325, and 10-16-429, C.R.S., including a statement that such a termination does not qualify as a special enrollment period during which the policyholder can enroll in another health benefit plan;
  - 3. To the policyholder that they may be required to pay all amounts owed for services incurred after the first month of the three (3) month grace period, including repayment of APTC received during the grace period;
  - 4. To providers with pended claims incurred in the second and/or third month of the policyholder's grace period that the claims may be denied if no further premium payments are received from the policyholder; and
  - 5. To the U.S. Department of Health and Human Services (HHS) of policyholder non-payment.

These notices, except for the notice found in paragraph 4, shall be provided regardless of whether or not claims are incurred during the three (3) month grace period. The notice in paragraph 4 in Section 5.C. of this regulation must only be provided if claims are incurred during the three (3) month grace period.

- D. The carrier must continue to collect advance payments of the premium tax credit on behalf of the policyholder during the three (3) month grace period.
- E. The carrier shall return the advance payments of the premium tax credit collected during the second and third month of the three (3) month grace period if all delinquent premium payments have not been received by the end of the third month.
- F. If a policyholder receiving APTC does not pay all outstanding premiums during the three (3) month grace period, the carrier must terminate coverage in accordance with §§ 10-16-222, 10-16-325, and 10-16-429, C.R.S.
- G. The carrier must receive all past-due premium from the policyholder prior to allowing the policyholder to change to another plan offered by the carrier.

#### **Section 6 Severability**

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

#### **Section 7 Enforcement**

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

#### **Section 8 Effective Date**

This regulation shall become effective on July 1, 2014.

#### **Section 9 History**

New regulation effective July 1, 2014.

### **Regulation 4-2-49 CONCERNING THE DEVELOPMENT AND IMPLEMENTATION OF A UNIFORM DRUG BENEFIT PRIOR AUTHORIZATION PROCESS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Form
Section 7	Severability
Section 8	Enforcement
Section 9	Effective Date
Section 10	History
Appendix A	Colorado Universal Prior Authorization Drug Benefit Request Form

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**Section 1      Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-124.5(3)(a), and 10-16-124.5(3)(c), C.R.S.

**Section 2      Scope and Purpose**

The purpose of this regulation is to establish the requirements, process, and form to be utilized by carriers and contracted pharmacy benefit management firms for the prior authorization process for prescription drug benefits.

**Section 3      Applicability**

Except as noted, the provisions of this regulation shall apply to all carriers that market health benefit plans in the state of Colorado which provide prescription drug benefits. The provisions of this regulation do not apply to non-profit health maintenance organizations with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group.

**Section 4      Definitions**

- A. "Adverse determination" shall have the same meaning as found at § 10-16-113(1)(b), C.R.S.
- B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S., and shall, for the purposes of this regulation, include a pharmacy benefit management firm contracted by a carrier.
- C. "Drug benefit" means, for the purposes of this regulation, the provision of a drug used to treat a covered medical condition of a covered person.
- D. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- E. "Health Maintenance Organization" shall have the same meaning as found at § 10-16-102(35), C.R.S.
- F. "Pharmacy benefit management firm" shall have the same meaning as found at § 10-16-102(49), C.R.S.
- G. "Prescribing provider" shall have the same meaning as found at § 10-16-124.5(8)(a), C.R.S.
- H. "Urgent prior authorization request" shall have the same meaning as found at § 10-16-124.5(8)(b), C.R.S.

**Section 5      Rules**

- A. Beginning on January 1, 2015, all carriers shall utilize the uniform prior authorization process established by this regulation.
- B. A prior authorization process for a drug benefit, as developed by a carrier, shall:
  - 1. Be made available electronically to the prescribing provider;
  - 2. Make the following information available and accessible in a centralized location on the carrier's or its designated pharmacy benefit management firm's website:
    - a. The prior authorization requirements and restrictions, including, but not limited to:

- 
- (1) The prescribing provider's obligation to respond to requests for additional information; and
      - (2) When requests will be deemed "approved" or "denied";
    - b. An alphabetical list of drugs, including both brand name and scientific name, that require prior authorization, including the clinical criteria and supporting references that will be used in making a prior authorization determination;
    - c. Written clinical criteria that include the criteria for reauthorization of a previously approved drug, if applicable, after the previous approval period has expired; and
    - d. The standard form for prior authorization for a drug benefit, provided in Appendix A of this regulation.
  - 3. Include evidence-based guidelines to be used by the carrier when making prior authorization determinations;
  - 4. Allow for, but not require, the electronic submission of prior authorization requests for a drug benefit to the carrier.
- C. Urgent prior authorization requests.
- 1. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within one (1) business day of receiving an urgent prior authorization request. Carriers shall include appropriate information on the expedited appeals process related to urgent care situations, as found in § 10-16-113, C.R.S., and associated regulations, with any denial of an urgent prior authorization request.
    - a. If additional information is required to process an urgent prior authorization request, the carrier must advise the prescribing provider of any and all information needed within one (1) business day of receiving the request.
    - b. If additional information is required to process an urgent prior authorization request, the prescribing provider shall submit the information requested by the carrier within two (2) business days of receiving such a request from the carrier.
    - c. If the additional information requested from the prescribing provider is not received within two (2) business days of the prescribing provider receiving such a request, the request shall be deemed denied. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the denial within one (1) business day of the date the request was deemed denied.
    - d. Once the requested additional information is received, the carrier shall make a determination in accordance with Section 5.C.1., of this regulation.
  - 2. If a carrier does not request additional information or provide notification of approval or denial, as required by Section 5.C.1., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the deemed approval within one (1) business day of date the request was deemed approved.
-

D. Non-urgent prior authorization requests.

1. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within two (2) business days of receiving a non-urgent prior authorization request that has been submitted through the carrier's electronic pre-authorization system.
  - a. If additional information is required, the carrier must advise the prescribing provider of any and all information needed within two (2) business days of receiving the non-urgent prior authorization request.
  - b. If additional information is required to process a non-urgent prior authorization request, the prescribing provider shall submit the information requested by the carrier within two (2) business days of receiving such a request from the carrier.
  - c. If the additional information requested from the prescribing provider is not received within two (2) business days of the prescribing provider receiving such a request, the request shall be deemed denied. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the denial within two (2) business days of the date the request was deemed denied.
  - d. Once the requested additional information is received, the carrier shall make a determination in accordance with Section 5.D.1. or Section 5.D.2., of this regulation, as applicable
2. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within three (3) business days of receiving a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation.
3. If a carrier does not request additional information or provide notification of approval or denial within:
  - a. Two (2) business days of the receipt of an electronically filed non-urgent prior authorization request, as required by Section 5.D.1., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the deemed approval within two (2) business days of the date the request was deemed approved; or
  - b. Three (3) business days of the receipt of a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation, as required by Section 5.D.2., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the deemed approval within two (2) business days of the date the request was deemed approved.

E. When notifying a prescribing provider of a prior authorization approval, a carrier shall include:

1. A unique prior authorization number attributable only to that drug benefit approval request;
2. Specifications for the particular approved drug benefit, and the source and date of the clinical criteria used to make the determination for each particular drug;

- 3. The next date for review of the approved drug benefit; and
  - 4. A link to the current criteria that will need to be submitted in order to reapprove the current prior authorization.
- F. When notifying a prescribing provider of a prior authorization denial, a carrier shall include a notice to the prescribing provider, and dispensing pharmacy, if provided, that the covered person has the right to appeal the adverse determination pursuant to §§ 10-16-113 and 10-16-113.5, C.R.S.
- G. A prior authorization approval is valid for at least one hundred eighty (180) days after the date of approval.
- H. If a prior authorization request is submitted electronically, verbally, via facsimile, or electronic mail, the response to that request shall be made through the same medium, or in a manner specifically requested by the provider.

**Section 6 Form**

Beginning on January 1, 2015, all carriers shall utilize the uniform prior authorization form found in Appendix A of this regulation.

**Section 7 Severability**

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

**Section 8 Enforcement**

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

**Section 9 Effective Date**

This regulation shall become effective on July 15, 2014.

**Section 10 History**

New regulation effective July 15, 2014.



APPENDIX A

[CARRIER LOGO]

[CARRIER NAME]

UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:

[CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM CONTACT INFORMATION]

<input type="checkbox"/> <b>Urgent</b> <sup>1</sup>		<input type="checkbox"/> <b>Non-Urgent</b>	
<b>Requested Drug Name:</b>			
<b>Patient Information:</b>		<b>Prescribing Provider Information:</b>	
Patient Name:		Prescriber Name:	
Member/Subscriber Number:		Prescriber Fax:	
Policy/Group Number:		Prescriber Phone:	
Patient Date of Birth (MM/DD/YYYY):		Prescriber Pager:	
Patient Address:		Prescriber Address:	
Patient Phone:		Prescriber Office Contact:	
Patient Email Address:		Prescriber NPI:	
		Prescriber DEA:	
Prescription Date:		Prescriber Tax ID:	
		Specialty/Facility Name (If applicable):	
		Prescriber Email Address:	
<b>Prior Authorization Request for Drug Benefit:</b>		<input type="checkbox"/> New Request <input type="checkbox"/> Reauthorization	
Patient Diagnosis and ICD Diagnostic Code(s):			
Drug(s) Requested (with J-Code, if applicable):			
Strength/Route/Frequency:			
Unit/Volume of Named Drug(s):			
Start Date and Length of Therapy:			
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:			
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]			
For use in clinical trial? (If yes, provide trial name and registration number):			
Drug Name (Brand Name and Scientific Name)/Strength:			
Dose:		Route:	
Quantity:		Frequency:	
Number of Refills:			
Product will be delivered to:		<input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician Office <input type="checkbox"/> Other:	
Prescriber or Authorized Signature:		Date:	
Dispensing Pharmacy Name and Phone Number:			
<input type="checkbox"/> <b>Approved</b>		<input type="checkbox"/> <b>Denied</b>	
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:			

<sup>1</sup>A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request

**Regulation 4-2-50      CONCERNING PEDIATRIC DENTAL COVERAGE REQUIREMENTS**

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

**Section 1      Authority**

This regulation is promulgated under the authority of §§ 10-1-109 and 10-16-103.4(7), C.R.S.

**Section 2      Scope and Purpose**

The purpose of this regulation is to establish a requirement that carriers cannot sell a health benefit plan in the individual or small group market inside or outside the Exchange that does not contain pediatric dental essential health benefit (EHB) coverage without obtaining reasonable assurance that such coverage has been purchased.

**Section 3      Applicability**

This regulation shall apply to all insurance carriers who offer individual and small group health benefit plans, and/or stand alone dental plans, issued or renewed on or after April 15, 2015, in the state of Colorado.

**Section 4      Definitions**

- A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- B. "Clear and conspicuous" means, for the purposes of this regulation, and with respect to a disclosure that the disclosure is reasonably understandable and designed to call attention to the nature and significance of the information it contains. A disclosure is considered designed to call attention to the nature and significance of the information in it if the carrier:
  - 1. Uses a typeface and type size that are easy to read;
  - 2. Provides wide margins and ample line spacing;
  - 3. Uses boldface, italics, underscoring, or capitals for key words and phrases; and
  - 4. In a form that combines the disclosure with other information, uses a plain-language heading to call attention to the disclosure portion of the document, and uses a type size that is greater than the type size predominantly used in the rest of the document.
- C. "Essential health benefits" and "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.

- D. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.
- E. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- F. "Patient Protection and Affordable Care Act" and "ACA" mean, for the purposes of this regulation, the Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

## **Section 5 Rules**

- A. Pediatric dental coverage is one of the ten (10) essential health benefits (EHB) that must be covered by health benefit plans subject to the requirements of the ACA.
- B. Obtaining pediatric dental coverage.
  - 1. Carriers selling individual and small group health benefit plans must ensure that consumers purchasing their health plans obtain pediatric dental EHB coverage.
  - 2. Carriers shall give consumers notice if the plan they have selected for purchase does not include the required pediatric dental EHB coverage.
  - 3. Carriers shall provide a clear and conspicuous notice to consumers on their websites or with all pediatric dental plan marketing materials describing how out-of-pocket maximums for stand-alone pediatric dental plans are treated differently than out-of-pocket maximums for dental plans that are provided with, or contained within, a health benefit plan. This notice shall also be provided to consumers as a separate document that is included with the dental plan policy documents given to policyholders.
  - 4. Carriers must be reasonably assured that the required pediatric dental EHB coverage has been purchased through one of the following methods:
    - a. The purchase of a health benefit plan which contains the required pediatric dental EHB coverage;
    - b. The purchase of a health benefit plan which provides the required pediatric dental EHB coverage through a contractual arrangement with a dental carrier; or
    - c. The purchase of a stand-alone dental plan that provides the required pediatric dental EHB coverage.
- C. In order for a carrier to sell an individual or small group health benefit plan that does not include coverage of the pediatric dental EHB, the carrier must be reasonably assured that a consumer has or will purchase such coverage. Reasonable assurance may be obtained by one or more of the following:
  - 1. Obtaining a certification from the consumer that they have purchased pediatric dental EHB coverage;
  - 2. Obtaining proof of purchase from the consumer who is a childless adult that they possess low-cost/no-cost child-only pediatric dental EHB coverage; or
  - 3. Obtaining an attestation as supplied on the individual application that the consumer has or will purchase pediatric dental EHB coverage.

- D. Supplying only the notice as required in Section 6 of this regulation does not constitute reasonable assurance.

**Section 6 Notices for No-Adult-Benefit Pediatric Dental Plans**

- A. Carriers must provide notice to consumers purchasing pediatric-only dental EHB coverage, whether in a standalone dental policy or as part of a health benefit plan, that such coverage does not provide any dental benefits to individuals age nineteen (19) or older.
- B. The required notice shall be prominently displayed on the first page of the policy form and shall be contained in all marketing materials for that policy.
- C. The required notice shall consist of the following language:

“This policy does not provide any dental benefits to individuals age nineteen (19) or older. This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If you want adult dental benefits, you will need to buy a plan that has adult dental benefits. This plan will not pay for any adult dental care, so you will have to pay the full price of any care you receive.”

**Section 7 Severability**

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

**Section 8 Enforcement**

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

**Section 9 Effective Date**

This regulation is effective April 15, 2015.

**Section 10 History**

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

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

- Section 1 Authority
- Section 2 Scope and Purpose
- Section 3 Applicability
- Section 4 Definitions
- Section 5 Discontinuance of Individual and Small Group Health Benefit Plans
- Section 6 Discontinuance of Large Group Health Benefit Plans and Student Health Insurance Coverage
- Section 7 Required SERFF Submissions
- Section 8 Severability
- Section 9 Enforcement
- Section 10 Effective Date

Section 11	History
Appendix A	Example Notice
Appendix B	Health Benefit Plan Discontinuances Summary Data Template
Appendix C	Health Benefit Plan Discontinuances by County Data Template

## **Section 1      Authority**

This regulation is promulgated under the authority of §§ 10-1-109, 10-16-105.1(6)(a), 10-16-105.7(3)(c), and 10-16-109, C.R.S.

## **Section 2      Scope and Purpose**

The purpose of this regulation is to establish standards for carriers in discontinuing health benefit plans pursuant to the requirements of Colorado law.

## **Section 3      Applicability**

This regulation shall apply to individual, small group, and large group health benefit plans and student health insurance coverage plans subject to the health insurance laws of Colorado.

## **Section 4      Definitions**

- A. "Carrier" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(8), C.R.S.
- B. "Creditable coverage" shall, for purposes of this regulation, have the same meaning as found at § 10-16-102(16), C.R.S.
- C. "Exchange" shall, for the purposes of this regulation, have the same meaning as set forth in § 10-16-102(26), C.R.S.
- D. "Health benefit plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(32), C.R.S.
- E. "Grandfathered health benefit plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(31), C.R.S.
- F. "SERFF" shall, for the purposes of this regulation, mean System for Electronic Rate and Form Filings.
- G. "Small group plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(63), C.R.S.
- H. "Student health insurance coverage" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(65), C.R.S.
- I. "Transition plan" shall, for the purposes of this regulation, mean non-compliant non-grandfathered health benefit plans that a carrier elected to continue into 2015, but that cannot continue beyond December 31, 2015.

**Section 5      Discontinuance of Individual and Small Group Health Benefit Plans**

- A. Prior to discontinuing any grandfathered or non-grandfathered individual or small group health benefit plans, a carrier must notify the Division of Insurance (Division) of such discontinuance by submitting a filing to the Division. All filings shall be submitted electronically via SERFF by a licensed entity. Failure to supply the required information specified in this regulation will render the filing incomplete, and such a filing may be rejected. A separate filing must be sent for each Line of Business being discontinued. The SERFF filing should be submitted as:
  - 1. Type of Filing "Other"; and
  - 2. Type of Insurance (TOI) code H21, or for HMO's code HOrg03.
- B. Until an individual or small group health benefit plan becomes subject to the provisions of HB13-1266, carriers electing to discontinue individual or small group plans must do so in accordance with the requirements found at § 10-16-201.5, C.R.S. (2012).
- C. For plans issued after January 1, 2014, carriers that elect to non-renew or discontinue individual or small group health benefit plans must do so in accordance with the requirements found at § 10-16-105.1(2)(g), C.R.S. The carrier shall offer policyholders the option of purchasing any other health benefit plan currently being offered by the carrier for which they qualify.
- D. The carrier shall provide notice of the decision not to renew or continue coverage to each policyholder at least ninety (90) days prior to the date of nonrenewal or discontinuance.
- E. Carriers shall include notice to the policyholder of eligibility for special enrollment periods, as established pursuant to § 10-16-105.7, C.R.S., with the nonrenewal or discontinuance notice.
- F. Carriers must use the notification language provided in Attachment A in order to provide sufficient notification to policyholders.
- G. Carrier discontinuance of a health benefit plan qualifies the policyholder for a special enrollment period pursuant to § 10-16-105.7(3), C.R.S. as an involuntary loss of creditable coverage.

**Section 6      Discontinuance of Large Group Health Benefit Plans and Student Health Insurance Coverage**

Large group carriers and student health insurance carriers must use the following guidelines when discontinuing large group health benefit plans or student health insurance coverage plans to ensure adequate consumer protection.

- A. When a large group or student health coverage carrier is discontinuing a particular plan, but is remaining in the large group market or student health insurance market, the carrier must provide notice of the decision to discontinue to each policyholder, certificate holder, participant, and beneficiary covered by the plan, no less than ninety (90) days prior to discontinuation. The notice found in Appendix A must be used. Additional communication with the policyholders regarding their enrollment options is not prohibited.
- B. The large group and student health coverage carrier must offer policyholders the option to purchase any other large group or student health benefit plan(s), respectively, currently offered by the carrier.

- C. The large group or student health coverage carrier must act uniformly without regard to the claims experience of the policyholders or any health status-related factor relating to any policyholder, certificate holder, participant, or beneficiary covered, or new participants or beneficiaries that may become eligible for such coverage.
- D. With respect to the discontinuance of a particular large group plan(s), the carrier must notify the Insurance Commissioner before providing the notification required in subsection A. above.
- E. A carrier discontinuing all of its large group health benefit plans or student health insurance coverage plans as part of an exit from that particular market segment shall comply with the requirements found at § 10-16-105.1(2)(h), C.R.S.

#### **Section 7 Required SERFF Submissions**

Carriers shall provide the following information via SERFF to the Division when discontinuing plans:

- A. The Form Schedule Tab in SERFF must be completed with the form name, form number, edition date, form type, and action for each policy form that is being discontinued. Listing the readability score and attaching the actual forms is not required.
- B. Copies of all proposed policyholder notices for Division review.
- C. A letter addressed to the Commissioner that contains a summary of the carrier's discontinuance actions must be attached as a supporting document and must contain the following information:
  - 1. Effective date of the discontinuance and/or exit from the market;
  - 2. The reason for the carrier's action;
  - 3. The market segment being exited or discontinued;
  - 4. Number of people affected (by county);
  - 5. Grandfathered/Non-Grandfathered status; and
  - 6. A statement as to whether or not the plan is a transition plan.
- D. The form found in Appendix B of this regulation shall be completed and included with this filing.
- E. The form found in Appendix C of this regulation shall be completed and included with this filing.

#### **Section 8 Severability**

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

#### **Section 9 Enforcement**

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

**Section 10      Effective Date**

This regulation shall become effective August 1, 2015.

**Section 11      History**

New regulation effective August 15, 2014.

Amended regulation effective August 1, 2015.



## **APPENDIX A – Carrier Discontinuance Notice**

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

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

This discontinuance triggers a special enrollment period which allows you to select a new health plan. You will have sixty (60) days before your plan ends and sixty (60) days after the date your plan ends to enroll in a new plan.

You may begin shopping for a new health benefit plan immediately to replace the plan that is ending, and you can enroll in a new health benefit plan up to sixty (60) days before your current plan ends, but you will need to be able to provide proof that your current plan is ending to the carrier of the plan you want to enroll in.

This notice can serve as the proof required for enrollment in a new plan. Knowing your plan is ending gives you the ability to enroll in a new plan with coverage beginning no earlier than the day this coverage ends so that you may avoid a gap in coverage.

[If carrier is offering new plans, use:

Your options include:

- Purchasing another [individual/small group/large group] health plan from us;
- Purchasing a plan from another carrier; or
- Purchasing a new plan through Connect for Health Colorado, where you may qualify for federal financial assistance ([www.connectforhealthco.com](http://www.connectforhealthco.com)).]

[If carrier does not offer new plans, use:

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

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

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

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

[If student health insurance coverage is involved, use:

If you are in need of a new student health insurance coverage plan, please contact your [school/college/university] directly to determine what plans are available.]

[illegible]

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

DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:				
SERFF FILING #:		111111	222222	333333
NAIC #:		44444	55555	66666
PLAN/PRODUCT NAME:		Plan X	Plan Y	Plan Z
ADAMS COUNTY			2	3
ALAMOSA COUNTY				
APAPAHOE COUNTY			3	6
ARCHULETA COUNTY				
BACA COUNTY				
BENT COUNTY				
BOULDER COUNTY			6	100
BROOMFIELD COUNTY			2	43
CHAFFEE COUNTY		1		1
CHEYENNE COUNTY				
CLEAR CREEK COUNTY				1
CONEJOS COUNTY				
COSTILLA COUNTY				
CROWLEY COUNTY				1
CUSTER COUNTY				
DELTA COUNTY				
DENVER COUNTY			8	200
DOLORES COUNTY				1
DOUGLAS COUNTY				50
EAGLE COUNTY				1
EL PASO COUNTY				3
ELBERT COUNTY				

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

DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:				
SERFF FILING #:		111111	222222	333333
NAIC #:		44444	55555	66666
PLAN/PRODUCT NAME:		Plan X	Plan Y	Plan Z
				<b>COUNTY TOTAL:</b>
FREMONT COUNTY			2	9
GARFIELD COUNTY				
GILPIN COUNTY				
GRAND COUNTY			3	150
GUNNISON COUNTY				
HINSDALE COUNTY				
HUERFANO COUNTY			6	40
JACKSON COUNTY			2	30
JEFFERSON COUNTY		1		1
KIOWA COUNTY				
KIT CARSON COUNTY				1
LA PLATA COUNTY				
LAKE COUNTY				
LARIMER COUNTY				1
LAS ANIMAS COUNTY				
LINCOLN COUNTY				
LOGAN COUNTY			8	125
MESA COUNTY				1
MINERAL COUNTY				60
MOFFAT COUNTY				1
MONTEZUMA COUNTY				3
MONTROSE COUNTY				
MORGAN COUNTY				

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

DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:				
SERFF FILING #:	111111	222222	333333	COUNTY TOTAL:
NAIC #:	44444	55555	66666	
PLAN/PRODUCT NAME:	Plan X	Plan Y	Plan Z	
OTERO COUNTY		2	12	14
OURAY COUNTY				
PARK COUNTY		3	45	48
PHILLIPS COUNTY				
PITKIN COUNTY				
PROWERS COUNTY		6	150	156
PUEBLO COUNTY		2	11	13
RIO BLANCO COUNTY	1			1
RIO GRAND COUNTY				
ROUTT COUNTY			1	1
SAGUACHE COUNTY				
SAN JUAN COUNTY				
SAN MIGUEL COUNTY			1	1
SEDGWICK COUNTY				
SUMMIT COUNTY				
TELLER COUNTY		8	120	128
WASHINGTON COUNTY			1	1
WELD COUNTY			75	75
YUMA COUNTY			1	1
OUT OF STATE			3	3
<b>TOTAL:</b>	<b>3</b>	<b>63</b>		<b>1616</b>

**Regulation 4-2-52 INSURER SPECIAL FEE ASSESSMENTS FOR THE COLORADO HEALTH  
BENEFIT EXCHANGE**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Insurer Reporting
Section 6	Special Fee Assessment
Section 7	Notice and Collection of Assessed Fees
Section 8	Severability
Section 9	Enforcement
Section 10	Effective Date
Section 11	History
Appendix A	Monthly Total Number of Lives Insured Reporting Form

**Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-22-109(3), C.R.S.

**Section 2 Scope and Purpose**

The purpose of this regulation is to establish rules governing the assessment and collection of fees necessary to assist in the funding of the Colorado Health Benefit Exchange.

**Section 3      Applicability**

This regulation shall apply to all insurers and carriers that are assessed special fees by the Exchange pursuant to state law.

**Section 4      Definitions**

- A. "Calendar year" means, for the purpose of this regulation, a year beginning on January 1 and ending on December 31.
- B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- C. "Exchange" shall have the same meaning as found at § 10-22-103(3), C.R.S.
- D. "Group health plan" shall have the same meaning as found at § 10-22-103(5), C.R.S.
- E. "Health benefit plan" shall have the same meaning as found at § 10-22-103(6), C.R.S.
- F. "Insurer" shall have the same meaning as found at § 10-22-103(7), C.R.S., and shall include, for the purposes of this regulation, carriers.
- G. "Number of lives insured" means, for the purpose of this regulation, the total number of employees and retired employees in the group market and the total number of individual policies in the individual market (excluding spouses and dependents) enrolled in a health plan who are residents of Colorado and whose plans are regulated by the Colorado Division of Insurance; and the total number of employees and retired employees who are residents of Colorado for whom a premium is paid and coverage is provided under an excess loss, stop loss or reinsurance policy issued by such insurer to an employer or group health plan whose plans are regulated by the Colorado Division of Insurance.

**Section 5      Insurer Reporting**

- A. No later than May 1 of each year, each insurer shall provide a report to the Exchange that includes:
  - 1. The total number of employees, retired employees and individual policyholders and/or subscribers in the individual and group markets enrolled in all of its health benefit plans who are residents of this state and whose plans are regulated by the Colorado Division of Insurance as of March 1 of calendar year in which the special fee assessment is being determined; and
  - 2. The number of employees and retired employees who are residents of this state for whom a premium is paid and coverage is provided under an excess loss, stop loss or reinsurance policy regulated by the Colorado Division of Insurance and issued by such insurer to an employer or group health plan as of March 1 of calendar year in which the special fee assessment is being determined.
- B. The report shall not include any employees, retired employees or individual policyholders and/or subscribers who receive health benefits through Medicare, Medicaid, the Children's Basic Health Plan (pursuant to article 8 of title 25.5, C.R.S.), or the Federal Employees Health Benefit Plans.
- C. Insurers providing stop loss, excess loss or reinsurance are permitted to exclude from their annual report those employees, retired employees, or individual policyholders or subscribers who have been counted by the primary insurer or primary reinsurer.

- D. Insurers shall provide the Exchange the monthly total number of lives insured on a quarterly basis utilizing the form found in Appendix A of this regulation. The total monthly number of lives insured shall reflect the total number of lives insured on the last day of each month. The number of total lives insured shall be provided to the Exchange no later than thirty (30) days after the end of the quarter. The monthly total number of lives insured shall assist in the quarterly reconciliation of special fees assessed. The insurer shall include an attestation with the quarterly report that the total number of lives insured provided is accurate.

**Section 6 Special Fee Assessment**

- A. The amount of special fees assessed shall be established in compliance with the requirements of § 10-22-109(2)(a), C.R.S. The Exchange shall communicate the amount of the special fees assessed to the Division, and that amount will be made public through the issuance of a bulletin.
- B. The amount of special fees due from each insurer each month is based upon the total number of lives insured in a month multiplied by the special fee assessed as determined by the Exchange.
- C. Special fees assessed shall not be considered as premium for any purpose, including, but not limited to, the calculation of gross premium tax or commission amounts.

**Section 7 Notice and Collection of Assessed Fees**

- A. The Exchange shall provide a notice to each insurer and to the Division of the special fee to be assessed for the coming calendar year no later than August 1 of each year.
- B. Insurers shall provide the Exchange with the monthly number of lives insured on a quarterly basis in accordance with the requirements of Section 5.D. of this regulation.
- C. Each insurer shall pay the special fees due to the Exchange on a quarterly basis. Payment for the previous quarter shall be made such that it shall be received by the Exchange no later than thirty (30) days after the end of quarter.
- D. In the event that any insurer fails to pay its special fee assessment, the Exchange shall send one (1) notice of nonpayment thirty (30) days after the date payment was to have been received by the Exchange. If the Exchange has not received payment of all amounts due from an insurer within thirty (30) days after the date of the notice of nonpayment, the Exchange shall report the non-payment to the Commissioner of Insurance.
- E. The Commissioner may suspend or revoke an insurer's certificate of authority to transact business in the State of Colorado due to non-payment of the special fees assessed. Prior to suspension or revocation of an insurer's certificate of authority, the Commissioner shall schedule a hearing in compliance with Article 4 of Title 24 of Colorado Revised Statutes. The Commissioner shall provide notice to the insurer of the date of the hearing no less than thirty (30) days prior to the date of the hearing. The notice of hearing shall also contain the amount of special fees owed to the Exchange, as well as instructions on how the insurer can pay all past-due special fees assessed.
- F. Any payments in arrears accrued after the first instance of non-payment is reported to the Division shall be included in the proceedings initiated to suspend or revoke an insurer's certificate of authority to transact business in the State of Colorado due to non-payment of the special fees assessed.

- G. Any insurer withdrawing from the Colorado market shall be liable for the assessment owed through the month of the date of withdrawal. The date of withdrawal shall be the date on which the last contract or policy of the insurer in Colorado is discontinued by the insurer in accordance with Colorado insurance laws, or is voluntarily terminated by the policyholder/ subscriber, whichever is sooner. The insurer shall not be liable for any assessment thereafter.
- H. Any insurer discontinuing all policies in a particular Colorado market segment (e.g. small group coverage) shall be liable for the assessment owed through the month when the last remaining policy(ies) has been discontinued in accordance with Colorado insurance laws, or is voluntarily terminated by the policyholder/subscriber, whichever is sooner. The insurer shall not be liable for any assessment owing thereafter.
- I. The special fee assessment amount must be clearly identified in any billing statement provided to consumers.

## **Section 8 Severability**

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

## **Section 9 Enforcement**

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

## **Section 10 Effective Date**

This regulation shall become effective January 1, 2015.

## **Section 11 History**

New regulation effective January 1, 2015.

## **Appendix A: Monthly Total Number of Lives Insured Reporting Form (to be submitted quarterly)**

[Insurer Name]

[Insurer Logo]

[Date Submitted]

### **Exchange Special Fees Assessed –Total Lives Insured Report for [Year]**

[Form to include past months]

<b>Month:</b>	<b>Total Lives Insured:</b>	<b>Date Report Run:</b>
January [Year]:		
February [Year]:		
March [Year]:		
April [Year]:		
May [Year]:		
June [Year]:		
July [Year]:		



August [Year]:		
September [Year]:		
October [Year]:		
November [Year]:		
December [Year]:		
<b>Year to Date:</b>		
<b>Total:</b>		

**Attestation:**

I, [Name], hereby certify and attest that the number of total lives insured contained above is accurate and true, and shall be used in reconciling the amount of special fees owed to the Exchange for Calendar Year [Year].

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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**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]*