MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2008

AETNA LIFE INSURANCE CO.
151 Farmington Avenue
Hartford, CT 06156

NAIC Company Code: 60054
NAIC Group Code: 00001

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

AETNA LIFE INSURANCE CO.
151 Farmington Avenue
Hartford, CT 06156

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2008

Examination Performed by:

State Market Conduct Examiners

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Violetta R. Pinkerton, CIE, MCM, CPCU, CPIW

Damion J. Hughes

And

Independent Contract Examiners

Howard Quinn, AIE, CLU, ChFC, CCP

Kathleen M. Bergen, CIE

October 15, 2009

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of Aetna Life Insurance Co. (the Company) was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which authorize the Commissioner of Insurance to examine insurance companies. The Company's records were examined at its Denver office located at 6501 S. Fiddler's Green Circle, Suite 310, Englewood, Colorado 80111 and the contract examiners reviewed selected electronic records off-site. The market conduct examination covered the period from January 1, 2008, through December 31, 2008.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Violetta R. Pinkerton, CIE, MCM, CPCU, CPIW

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COMPANY PROFILE

The following profile is based on information provided by the Company:

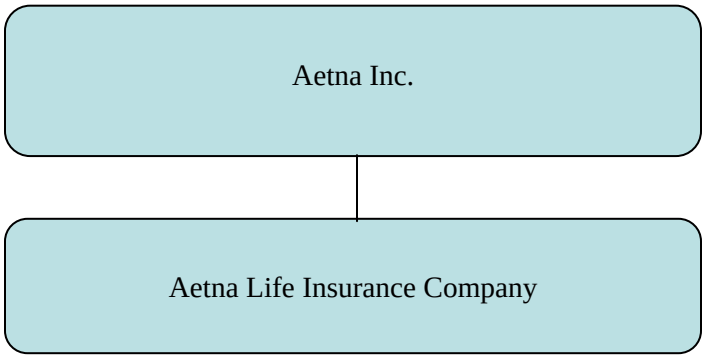
Aetna Life Insurance Company (ALIC) was incorporated in Connecticut in June, 1853. ALIC was a publicly held corporation until 1967, when all the outstanding shares of its stock were acquired by Aetna Life and Casualty Company ("AL&C") in a share exchange. In 1996, AL&C changed its name to Aetna Services, Inc. ("ASI") and became a wholly owned subsidiary of Aetna Inc., a Connecticut corporation ("Old Aetna"). On October 31, 2000, ASI merged into Old Aetna, and on November 3, 2000 ALIC became a wholly-owned subsidiary of Aetna U.S. Healthcare Inc., a Pennsylvania corporation ("New Aetna"), which was a wholly owned subsidiary of Old Aetna at such time. On December 13, 2000, Old Aetna sold its financial services and international businesses and simultaneously spun-off New Aetna to its shareholders. On the same date, New Aetna was renamed Aetna Inc. Shares of New Aetna are traded on the New York Stock Exchange. ALIC is a for profit stock corporation.

ALIC was licensed and began operation in Colorado on February 26, 1889.

An abbreviated organizational chart depicting the Company's relationship with its ultimate controlling person, as of December 31, 2008 is presented below:

STRUCTURE AS OF DECEMBER 31, 2008

An abbreviated organizational chart depicting the Company's relationship with its ultimate controlling person and other affiliates, as of December 31, 2008 is presented below.



Territory and Plan of Operation
ALIC is licensed as a life, accident and health insurer in all states and the District of Columbia. ALIC is also licensed in Guam, Puerto Rico and the U.S. Virgin Islands. Business written out of ALIC includes: Large Case Pensions, Group Insurance, Dental and Non-HMO Health products. ALIC offers and issues both small and large group health insurance policies in Colorado.

Enrollment:

Large Group:	20,049
Small Group:	8,328
Individual:	10,381

Premium and Market Share as of December 31, 2008:

Total Premium:	$282,449,000*
Large Group:	$160,528,000
Small Group:	$73,378,000
Individual:	$28,316,013*

Market Share: (as a percentage of Colorado Total Accident and Health) 3.03%

*As shown in the 2008 Edition of the Colorado Insurance Industry Statistical Report

PURPOSE AND SCOPE OF EXAMINATION

State market conduct examiners with the Colorado Division of Insurance (Division), who were assisted by independent contract examiners, reviewed certain business practices of Aetna Life Insurance Co. (the Company). The limited market conduct examination was performed in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., that empower the Commissioner to examine any entity engaged in the business of insurance. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related to health insurance companies. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

Examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or provided by the Company. The limited market conduct examination covered the period from January 1, 2008, through December 31, 2008.

The examination included review of the following:

Company Operations and Management
Producers
Contract Forms
New Business Applications and Renewals
Rating
Cancellations/Declinations/Non-Renewals/Rescissions
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain any improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to individual, small and large group health insurance laws. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims, or ten percent (10%) for other samples, was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate higher than the minimum tolerance level, the results of any other samples with exception percentages less than the minimum tolerance threshold were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration.
Section 10-2-401, C.R.S.	License required.
Section 10-2-702, C.R.S.	Commissions
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-8-521, C.R.S.	Notice to residents.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age.
Section 10-16-104.7, C.R.S.	Substance abuse – court-ordered treatment coverage
Section 10-16-105, C.R.S.	Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans – rules.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-107	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-113.7, C.R.S.	Reporting the denial of benefits to the division – rule
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-704, C.R.S.	Network adequacy.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning The Elements Of Certification For Accident and Health Forms
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review And Denial Of Benefits
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions

Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issue to Self-employed Business Groups of One
Insurance Regulation 4-2-20	Concerning the Colorado Health Benefit Plan Description Form
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers
Insurance Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Health Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Conversion Coverage

Prior Examinations

The Company has not been the subject of a previous market conduct or financial examination by the Division.

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, administrative, underwriting and claims guidelines/procedures, and timely cooperation with the examination process.

Producers

The examiners reviewed the licensing status of the submitting producers for the samples of the files selected in the new business applications section of the examination for compliance with the appropriate Colorado statutes and regulations.

Contract Forms

The examiners reviewed the following forms:

- The Company Co-payment Schedules, Evidences of Coverage and Schedule of Benefits;
- The Company's most commonly sold individual and group contracts marketed to individuals, small groups and associations;
- The Company's conversion contracts, application form, definitions, eligibility, and termination provisions; and
- The Company's group, individual, and employee applications/enrollment forms and supporting documents.

These forms were issued and/or certified with the Division between January 1, and December 31, 2008.

New Business Applications and Renewals

For the period under examination, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- One hundred sixteen (116) individual new business application files from a population of 16,037;
- Eighty-four (84) small group new business application files from a population of 426;
- One hundred sixteen (116) renewed individual files from a population of 23,008; and

- One hundred fourteen (114) renewed small group files from a population of 1,595.

Rating

The examiners reviewed the premium rates charged in the samples of the files selected in the new business applications section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Division as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

Cancellations/Declinations/Non-Renewals/Rescissions

For the period January 1, 2008 through December 31, 2008, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- One hundred sixteen (116) individual cancellation/non-renewal files from a population of 6,043;
- One hundred thirteen (113) small group cancellation/non-renewal files from a population of 700;
- One hundred thirteen (113) individual declined files from a population of 594;
- Seventy-six (76) association plan (AARP) declined files from a population of 173;
- The entire population of twenty-three (23) small group declined files; and
- The entire population of two (2) rescissions.

Claims

- One hundred nine (109) paid claims from a population of 381,600 claims received during the examination period.
- One hundred nine (109) denied claims from a population of 47,169 received during the examination period.

The above two samples were reviewed for overall claim handling and accuracy of payment.

- One hundred nine (109) electronic claims from a population of 18,727 electronic claims received during the examination period.
- One hundred eight (108) non-electronic claims from a population of 2,465 non-electronic claims received during the examination period.
- One hundred nine (109) electronic and non-electronic claims from a population of 7,448 electronic and non-electronic claims received during the examination period.

The above three samples were reviewed to determine the Company's compliance with Colorado's prompt payment of claims law.

Utilization Review

The examiners reviewed the Company's utilization review (UR) management program including policies and procedures. For the period of January 1, 2008 through December 31, 2008, the examiners reviewed the following for compliance with statutory requirements:

- One hundred sixteen (116) UR approval files from a population of 14,094;
- One hundred thirteen (113) UR declination files from a population of 959;
- Seventy-nine (79) First Level UR appeal files from a population of 104;

- The entire population of nine (9) Second Level UR appeal files; and
- The entire population of twelve (12) External Review UR appeals.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of forty-five (45) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

Company Operations and Management: The examiners identified one (1) area of concern in their review of the Company's Operations and Management.

Issue A1: Failure to include some required provisions in PPO provider contracts.

Contract Forms: The examiners identified thirty-one (31) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and any riders).

Issue E1: Failure, in some instances, to provide correct information regarding coordination of benefits with automobile insurance.

Issue E2: Failure, in some instances, to provide accurate Lifetime or Maximum Benefit levels as required under Colorado insurance law.

Issue E3: Failure, in some instances, to correctly state the work status requirements for an employee's eligibility for coverage under the Company's small group health benefit plans.

Issue E4: Failure, in some instances, to provide coverage for cervical cancer vaccine as mandated under Colorado insurance law.

Issue E5: Failure, in some instances, to provide coverage for the required number of well child visits in policy forms as required under Colorado insurance law.

Issue E6: Failure, in some instances, to provide a complying definition of complications of pregnancy in the Company's policy forms as required under Colorado insurance law.

Issue E7: Failure, in some instances, to provide the required notice of the right of an independent external review of benefit denials in its Basic and Standard health benefit plan forms.

Issue E8: Failure, in some instances, to provide correct deductibles and out-of-pocket expense information in the Basic and Standard health benefit plan forms.

Issue E9: Failure, in some instances, to provide correct information regarding mandated coverage for outpatient physical, occupational, and speech therapy.

Issue E10: Failure, in some instances, to correctly state the annual prescription deductible in the Basic and the prescription drug copayment in the Standard health benefit plan forms.

Issue E11: Failure of the Company's forms, in some cases, to reflect the required number of home health care visits.

Issue E12: Failure, in some instances, to allow benefits for covered services based on a licensed provider's status as a family member or a member of the insured's or insured dependent's household.

Issue E13: Failure, in some instances, to provide correct information regarding the requirement for precertification.

Issue E14: Failure, in some cases, to include correct information regarding the time periods for application of preexisting condition limitations.

Issue E15: Failure, in some cases, to reflect the correct minimum benefit level for mammography in individual policies.

Issue E16: Failure, in some instances, to proscribe the use of genetic testing in connection with a preexisting condition.

Issue E17: Failure, in some instances, to provide an offer of coverage for overage dependents.

Issue E18: Failure, in some cases, to accurately reflect the time periods in which claims should be paid.

Issue E19: Failure, in some instances, to include coverage for early intervention services as required under Colorado insurance law.

Issue E20: Failure, in some instances, to reflect correct information regarding an insured's option to assign claim benefits directly to providers.

Issue E21: Failure, in some instances, to provide coverage for mandated organ transplants.

Issue E22: Failure, in some instances, to provide for continuation of insurance for a Member or Dependent merely because they qualify or are eligible for Medicare or Medicaid.

Issue E23: Failure, in some instances, to correctly define a significant break in coverage as it pertains to pre-existing conditions exclusions.

Issue E24: Failure, in some cases, to reflect mandated coverage for inherited enzymatic disorders.

Issue E25: Failure, in some instances, to provide coverage for a newly acquired dependent from the date of birth, adoption, or placement for adoption without preexisting condition or other restrictions unless enrolled within thirty-one (31) days, even when the addition of said dependent would not result in any additional premium to cover the newborn or adopted child.

Issue E26: Failure, in some instances, to include accurate information regarding coordination of benefits with Medicare.

Issue E27: Failure, in some instances, to provide information regarding coverage and benefits that is not misleading and/or contradictory in accordance with Colorado insurance law.

Issue E28: Failure, in some instances, to include a correct definition of an eligible dependent in accordance with Colorado insurance law.

Issue E29: Failure, in some instances, to correctly and completely define coverage for Cleft Lip and Cleft Palate and to cover all required benefits.

Issue E30: Failure, in some instances, to correctly and completely define eligibility for a second level review in accordance with Colorado insurance law.

Issue E31: Failure, in some instances, to include mandated coverage for hospitalization and general anesthesia for dental procedures for dependent children in accordance with Colorado insurance law.

Rating: The examiners identified one (1) issue in their review of rating.

Issue F1: Failure to submit a rate filing for the AARP medical expense insurance plan prior to using the rates and marketing the plan.

New Business Applications and Renewals: The examiners identified one (1) issue in their review of new business applications and renewals.

Issue G1: Failure of the Company's small group renewal forms, to provide accurate information regarding dependent coverage.

Cancellations/Non-Renewals/Declinations/Rescissions: The examiners identified three (3) areas of concern identified during the review of the cancellations, non-renewals, declination, and rescission files.

Issue H1: Failure to reflect the full definition of a significant break in coverage in the certificate of creditable coverage notice forms.

Issue H2: Failure, in some instances, to provide written notice of the availability of small group coverage to business groups of one upon denial of coverage under an individual plan.

Issue H3: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plans.

Claims: The examiners identified three (3) areas of concern in their review of the claims handling practices of the Company.

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay correct interest and/or penalty on claims not paid, denied, or settled within the time frames required by Colorado insurance law.

Issue J3: Failure, in some instances, to request additional information required for the adjudication of unclean claims in accordance with Colorado insurance law.

Utilization Review: The examiners identified five (5) areas of concern in their review of the Company's Utilization Review procedures.

Issue K1: Failure, in some instances, to comply with the notification requirements pertaining to an external review.

Issue K2: Failure, in some cases, to ensure that the majority of the appeal review committee was comprised of health care professionals with the appropriate expertise in relation to the case for second level reviews.

Issue K3: Failure, in some cases, to provide the names, titles and qualifying credentials of participants in second level reviews.

Issue K4: Failure, in some cases, to provide all required disclosures to covered persons or their representatives for second level reviews.

Issue K4: Failure, in some cases, to provide all required disclosures to covered persons or their representatives for second level reviews.

Issue K5: Failure, in some cases, to include the name, title and qualifying credentials of the physician who evaluated the appeal and the qualifying credentials of the clinical peer(s) with whom the physician consulted in first level review decision letters.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

AETNA LIFE INSURANCE CO.

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure to include some required provisions in PPO provider contracts.

Section 10-16-121, C.R.S., Required contract provisions in contracts between carrier and providers states in part:

(1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan shall make provisions for the following requirements:

(a) The contract shall contain a provision stating that neither the provider nor the carrier shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the carrier or provider.

(b) The contract shall contain a provision that states the carrier shall not terminate the contract with a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier's decision or because a 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 of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients.

(d) The contract shall contain a provision that the provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers in the health plan for covered benefits so long as the provider making the referral adheres to the carrier's or the carrier's intermediary's utilization review policies and procedures.

Colorado Insurance Regulation 4-2-15, Required Provisions in Carrier Contracts With Providers and Intermediaries Negotiating on Behalf of Provider, promulgated pursuant to Sections 10-1-109 and 10-16-121(5), C.R.S., states in part:

V. Rules

I. Each and 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 after January 1, 1997, shall contain provisions substantially similar to the following:

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

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

C. "[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 assists the covered person to seek reconsideration of the carrier 's decision, or because a 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 of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients."

It appears that in some instances, the Company's PPO provider contracts are not in compliance with Colorado insurance law in that they do not contain a provision that allows a provider to protest a decision by the Company or assist the member patient with a reconsideration of a Company decision without penalty or termination of the contract with the provider. In addition, there is no provision in the Primary Care Physician contract concerning a prohibition against financial disincentives that may discourage a provider from referring members to other providers.

Contract:	Date:
CO/Primary Care Physician Agreement	2.07
CO/Hospital Services Agreement	2.07

Recommendation No 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-121, C.R.S. and Colorado Insurance Regulation 4-2-15. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has modified its provider contracts to ensure that they contain all provisions required by Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure, in some instances, to provide correct information regarding coordination of benefits with automobile insurance.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(a) Misrepresentations and false advertising of insurance policies: Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, circular, statement, sales presentation, omission, or comparison which:

(I) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

During the review of the Company's contract forms, it was noted that in some instances, the coordination of benefits provision indicates benefits will be coordinated with coverage required under the Colorado Auto Accident Reparations Act (No-Fault) which was repealed as of July 1, 2003. Following is this reference in the Company policies:

"Part V-COORDINATION WITH OTHER BENEFITS

No-Fault Auto Coordination

Benefits under this Plan will be coordinated with the applicable minimum coverage's required under the Colorado Auto Accident Reparations Act (No-Fault), Colorado Revised Statutes 1973, as amended.

If a "No-Fault" Policy provides coverage in excess of the minimum required by State law then we will coordinate benefits with those coverage's in effect
.

WHAT IF THE PERSON FAILS TO PURCHASE THE REQUIRED NO-FAULT COVERAGE ON HIS OR HER AUTOMOBILE:

The benefits of this Plan will not be available to the person to the extent of minimum benefits required by the "No-Fault" Law for injuries suffered by the person while operation or riding in a motor vehicle owned by the person if said vehicle is in operation on the public highways of the State of Colorado and such vehicle is not covered by No-Fault Automobile Insurance as required by Law. However, this Plan does not coordinate benefits relating to any other person injured in a motor vehicle if the injured person is a non-owner operator, passenger or a pedestrian and such other person is not covered by No-Fault Automobile Insurance."

The following policies did not appear to be in compliance with Colorado insurance law:

Form Number:		Date
GR-94275	Basic Limited Mandate Health Benefit Plan	Ed. 1/06
GR-94276	Standard Indemnity Plan	Ed. 1/06
GR-94279	Basic Preferred Provider Plan	Ed.1/06
GR-94280	Standard Preferred Provider Plan	Ed. 1/06
GR-94280-A/AS	Standard Preferred Provider Plan	Ed. 1/06

Recommendation Number 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable forms to remove reference to the repealed Colorado no-fault (PIP) statutes as required by Colorado insurance law.

Issue E2: Failure, in some instances, to provide accurate Lifetime or Maximum Benefit levels as required under Colorado insurance law.

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2 Scope and Purpose

The purpose of this regulation is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard health benefit plans required to be offered to small employer groups and which are used for the purpose of conversion from group coverage as well as to incorporate other changes necessary for compliance with Colorado law. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.

Part B: Summary of benefits

	BASIC INDEMNITY PLAN	BASIC PPO PLAN	
Basic LIMITED MANDATE Health Benefit Plan		IN-NETWORK	OUT-OF-NETWORK [2]
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$ 2 million	$ 5 million	

Part C: Summary of benefits

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN
1. TYPE OF PLAN	Medical expense policy	Preferred provider organization plan (PPO)
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$ 2 million	$ 5 million [Emphases added.]

It appears that the Company's Basic and Standard health benefit plans are not in compliance with Colorado insurance law in that they do not reflect the correct lifetime or benefit maximums for plans issued during 2008. The Company's Lifetime policy limits for each of the Basic or Standard policies offered during 2008 reflect the following:

Basic Indemnity Limited Mandate Health Benefit Plan

Overall Lifetime Maximum Payment Limit

Comprehensive Medical Lifetime Maximum Payment Limit for each person during his or her lifetime for all causes is $1,000,000."

The correct amount should be $2 million.

Basic Preferred Provider Limited Mandate Health Benefit Plan

Overall Lifetime Maximum Payment Limit

The Comprehensive Medical Lifetime Maximum Payment Limit for each person during his or her lifetime for all causes is $2,000,000.

The correct amount should be $5 million.

Standard Indemnity Plan

Overall Lifetime Maximum Payment Limit

The Comprehensive Medical Lifetime Maximum Payment Limit for each person during his or her lifetime for all causes is $1,000,000.

The correct amount should be $2 million.

Standard Preferred Provider Plan

Overall Lifetime Maximum Payment Limit

The Comprehensive Medical Lifetime Maximum Payment Limit for each person during his or her lifetime for all causes is $2,000,000.

The correct amount should be $5 million.

Standard PPO Plan Including Alcohol and Drug Treatment

Overall Lifetime Maximum Payment Limit

The Comprehensive Medical Lifetime Maximum Payment Limit for each person during his or her lifetime for all causes is $2,000,000.

The correct amount should be $5 million.

During the review of the above policy forms, it was noted that the revised or edition date was in 2006. Therefore it appears that the Company has not updated these forms to reflect the 2008 changes as required under Colorado Insurance Regulation 4-6-5 concerning lifetime maximum benefits for health benefit policies.

The following are the form numbers that did not appear to be in compliance with Colorado insurance law:

Form Number and Name		Date:
GR-94275	Basic Limited Mandate Health Benefit Plan	Ed. 1/06
GR-94276	Standard Indemnity Plan	Ed. 1/06
GR-94279	Basic Preferred Provider Plan	Ed. 1/06
GR-94280	Standard Preferred Provider Plan	Ed. 1/06
GR-94280-A/AS	Standard Preferred Provider Plan	Ed. 1/06

Recommendation Number 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable forms to correct the Lifetime Maximum Benefits limit as required by Colorado insurance law. A self audit should be conducted to ensure that claims exceeding the improperly-stated maximum benefit levels, but within the statutorily-required maximum benefit levels, were paid properly.

Issue E3: Failure, in some instances, to correctly state the work status requirements for an employee's eligibility for coverage under the Company's small group health benefit plans.

Section 10-16-102, C.R.S., Definitions, states in part:

(15)(a) *"Eligible employee" means an employee who has a regular work week of twenty-four or more hours* and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, *but does not include an employee who works on a temporary or substitute basis*.

(c) *Nothing in this subsection (15) is intended to limit the employer's traditional ability to set valid and acceptable standards for employee eligibility based on the terms and conditions of employment, including a minimum weekly work requirement in excess of twenty-four hours and eligibility based upon salaried versus hourly workers and management versus nonmanagement workers.* [Emphasis added.]

Colorado Insurance Regulation 4-6-8, Concerning Small Employer Health Plans, promulgated under the authority of §§ 10-1-09(1), 10-16-105.2(1)(a)(IV) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109 and 10-16-708, C.R.S., states in part:

Section 5. Issuance Of Coverage

(B) Determining Who is an Eligible Employee, Dependent

(1) The Colorado Division of Insurance Finds that, when defining "eligible employee" in Section 10-16-102(15), C.R.S., the sole intent of the General Assembly was to create a maximum weekly work requirement which small employer carriers may impose as a requirement for an employee's participation in a health benefits plan. Nothing in the definition of "eligible employee" was intended to limit an employer's traditional ability to set valid and acceptable standards for employee eligibility based upon the terms and conditions of employment, including a minimum weekly work requirement in excess of twenty-four (24) hours and eligibility based upon salaried versus hourly workers and management versus non-management employees.

(2) The Division finds that, subject to other statutory restrictions and the provisions of this regulation, a small employer carrier may offer a health benefit plan to the eligible employees of a small employer as that employer defines its eligible employees (herein after referred to as "employer-determined eligible employees"). However, *a carrier must offer coverage to all small employers for all employees with a regular work week of at least 24 hours on a regular basis. The decision of the small employer to limit eligibility for coverage as provided for in subparagraph (1) of this subsection B shall be solely at the small employer's discretion, without direct or indirect pressure or suggestion by the carrier, producer, or their representatives.* The small employer

> carrier may offer coverage only to such employer-determined eligible employees and their dependents and may apply its minimum participation and contribution criteria solely to such employer-determined eligible employees. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that in some cases, its small group policy forms contain an eligibility provision that excludes employees who may work the required twenty-four (24) hours weekly but could be considered part-time rather than full-time employees by their employer. Colorado insurance law defines an eligible employee as anyone who has a regular work week of twenty-four (24) or more hours, except temporary or substitute employees. The question of part-time vs. full-time is not a factor unless the small employer has defined a minimum weekly work requirement in excess of twenty-four (24) hours.

Additionally, the eligibility provision omits any mention of "employer-determined eligible employees" where it is the sole discretion of the small employer to limit coverage based upon the terms and conditions of employment, including eligibility based upon salaried versus hourly employees and management versus non management employees.

The Company's health plans provision for eligibility states in part:

> **Eligibility**
>
> To be eligible for coverage you must be a member.
>
> **Member** means an Eligible Employee who is regularly scheduled to work for the Policyholder for at least 24 hours a week, *excluding persons who work on a part-time*, temporary, or substitute basis. [Emphasis added.]
>
> **Eligible Classes (GR-29)**
>
> All classes of employees of a Member Employer are eligible except those who are:
>
> *Part-time;* [Emphasis added.]
>
> Temporary;
>
> Substitute; or
>
> In a class for which a Certificate is not in this policy**.**

The following policy forms do not appear to be in compliance with Colorado insurance laws:

Form Number and Name		Date
GR-29	Group Accident and Health Insurance Policy	7/73
GR-9427	Indemnity Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94276	Indemnity Plan – Standard Health Benefit Plan	1/06
GR-94279	Preferred Provider Plan – Basic Limited Mandate health Benefit Plan	1/06
GR-94280	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-94280-A/SA	Preferred Provider Plan – Standard Health Benefit Plan	1/06

Recommendation Number 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-102, C.R.S., and Colorado Insurance Regulation 4-6-8. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable forms to reflect correct employee eligibility requirements for work status as required by Colorado insurance law.

Issue E4: Failure, in some instances, to provide coverage for cervical cancer vaccine as mandated under Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(17) Cervical cancer vaccines.

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, *shall provide coverage for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended* by the advisory committee on immunization practices of the United States department of health and human services.

(b) *The requirements of this subsection (17) shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after January 1, 2008, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated on or after January 1, 2008.* [Emphases added]

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2. Scope and Purpose

The purpose of this regulation is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard health benefit plans required to be offered to small employer groups and which are used for the purpose of conversion from group coverage as well as to incorporate other changes necessary for compliance with Colorado law. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3. Applicability

This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.

Attachment 1

Covered Preventive Services [1]	
Females	Full cost of cervical cancer vaccine

It appears that in some instances, the Company's forms are not in compliance with Colorado insurance law in that they do not provide the mandated coverage for cervical cancer vaccines.

The following policy forms do not appear to be in compliance with Colorado insurance laws:

Form:		Date:
GR-94275	Basic Limited Mandate Health Benefit Plan	1/06
GR-94276	Standard Indemnity Plan	1/06
GR-94279	Basic Preferred Provider Plan	1/06
GR-94280	Standard Preferred Provider Plan	1/06
GR-94280-A/AS	Standard Preferred Provider Plan	1/06
GR-11741	Comprehensive Medical Expense Policy	8/06
GR-11741-SOC-PPO-2,500		8/06
GR-29	Group Accident and Health Insurance Plan	No Date
GR-9	Group Health Plan	No Date
GR-9N-02-005-10054-01-DC	AARP Essential Premier Booklet-Certificate	No Date
GR-9N-S-10-10-05-10054	AARP Essential Premier Schedule of Benefits	No Date
GR-9N-CR-1-10054-01-CO	AARP ET Amendment Rider	No Date

Recommendation Number 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S., and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to provide coverage for cervical cancer vaccine as required by Colorado insurance law.

Issue E5: Failure, in some instances, to provide coverage for the required number of well child visits in policy forms as required under Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(11) Child health supervision services.

(a) *For purposes of this subsection (11), unless the context otherwise requires, "child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2), to dependent children up to age thirteen.* Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

(b) *An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services.* A plan described in this paragraph (b) may provide that child health supervision services rendered during a periodic review shall only be covered to the extent such services are provided during the course of one visit by or under the supervision of a single physician, physician's assistant, or registered nurse. [Emphases added.]

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2 Scope and Purpose

The purpose of this regulation is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard health benefit plans required to be offered to small employer groups and which are used for the purpose of conversion from group coverage as well as to incorporate other changes necessary for compliance with Colorado law. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Part B: Summary of benefits

	BASIC INDEMNITY PLAN	BASIC PPO PLAN	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		IN NETWORK	OUT-OF-NETWORK [2]

9. PREVENTIVE CARE [6] a)Children's services (No deductible prior to application of coinsurance.)	50% coinsurance	$40 copay/visit	50% coinsurance

Part B: Summary of benefits

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN	
9. PREVENTIVE CARE [6] a) Children's services (No deductible prior to application of coinsurance)	80% coinsurance	$25 copay/visit	50% coinsurance

6 See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Division of Insurance Bulletin 4-24.

Attachment 1

	Covered Preventive Services [1]
Age 0-12 months	**6 well child visits**
Age 13-35 months	**3 Well child visits**
Age 3-6	**4 Well Child visits**
Age 7-12	**4 Well child visits**

It appears that in some instances, the Company's individual and group health benefit plan forms are not in compliance with Colorado insurance law in that they do not reflect the current requirements for well child visits. The Company's forms provide the following information regarding well child visit coverage in part:

Age 0-12 months	5 Well child visits
Age 13-35 months	2 Well child visits
Age 3-6	3 Well child visits
Age 7-12	3 well child visits

During the review of policy forms, it was noted that some forms had a revised or edition date that was in 2006. Therefore it appears that the Company has not updated these forms to reflect the 2008 changes as required under Colorado Insurance Regulation 4-6-5 concerning the number of well child visits.

The following are the form numbers and group plans which do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-94275 Basic Limited Mandate Health Benefit Plan	1/06
GR-94276 Standard Indemnity Plan	1/06
GR-94279 Basic Preferred Provider Plan	1/06
GR-94280 Standard Preferred Provider Plan	1/06
GR-9 Group Health Plan	No Date
GR-11741 Individual Medical Expense	8/06
GR-11741-SOC-PPO-500 (Individual)	8/06
GR-94280-A/AS Standard Preferred Provider Plan	1/06

Recommendation Number 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S., and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect the correct number of well child care visits as required by Colorado insurance law. In addition, the Company should be required to perform a self-audit to correct any claims for well child visits that were denied.

Issue E6: Failure, in some instances, to provide a complying definition of complications of pregnancy in the Company's policy forms as required under Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(2) Complications of pregnancy and childbirth.

(b) Any sickness and accident insurance policy providing coverage for sickness on an expense-incurred basis shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy.

Colorado Insurance Regulation 4-2-6, Concerning The Definition Of The Term "Complications Of Pregnancy", promulgated under the authority granted to the Commissioner of Insurance under Sections 10-1-109, 10-16-109 and 10-3-1110, C.R.S. states in part:

Section 2. Purpose

The purpose of this regulation is to standardize the definition of the term "complications of pregnancy" as employed 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. Scope

This regulation shall apply to all entities marketing or selling policies of sickness and accident insurance within the State of Colorado; except that this regulation will not apply to Medicare supplement insurance policies and a waiver of premium or double indemnity benefit included in a life insurance policy or annuity contract.

Section 4. Definitions

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

(1) 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;

(2) Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Section 5. Rules

> *All insurers marketing sickness and accident insurance policies, as defined in this regulation, delivered or issued for delivery in the State of Colorado shall employ in each insurance policy or certificate of insurance a definition of the complications of pregnancy no more restrictive than that required by this regulation.* [Emphasis added]

It appears that in some instances, the Company's individual and group health benefit plan forms are not in compliance with Colorado insurance law in that they do not reflect a complying definition of "complications of pregnancy".

The following policy form numbers do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-94275 Basic Limited Mandate Health Benefit Plan	1/06
GR-94276 Standard Indemnity Plan	1/06
GR-94279 Basic Preferred Provider Plan	1/06
GR-94280 Standard Preferred Provider Plan	1/06
GR-94280-A/AS Standard Preferred Provider Plan	1/06
GR-11741 Comprehensive Medical Expense Policy	8/06
GR-11741-SOC-PPO-2,500	8/06
GR-9 CO Group Health Plan	No date

Recommendation Number 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S., and Colorado Insurance Regulation 4-2-6. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect a complying definition of complications of pregnancy as required by Colorado insurance law.

Issue E7: Failure, in some instances, to provide the required notice of the right of an independent external review of benefit denials in its Basic and Standard health benefit plan forms.

Section 10-16-113.5, C.R.S., Independent external review of benefit denials-legislative declaration-definitions, states in part:

> 6) All health coverage plan materials dealing with the plan's grievance procedures shall advise covered persons in writing of the availability of an independent external review process, the circumstances under which a covered individual requesting an independent external review may use the independent external review process, the procedures for requesting an independent external review, and the deadlines associated with an independent external review.

Colorado Insurance Regulation 4-2-21, External Review Of Benefit Denials Of Health Coverage Plans, promulgated under the authority of §§10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states in part:

> Section 5. Notice and Disclosure of Right to External Review
>
> B. Disclosure requirements.
>
> 1. Effective for policies issued or renewed on or after June 1, 2000, *each carrier shall include a description of the external review procedures in or attached to all health coverage plan materials dealing with the plan'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. [Emphases added]

It appears that the Company's Basic and Standard health benefit plans are not in compliance with Colorado insurance law in that they do not reflect the required notice concerning an independent external review of benefit denials.

The following are the form numbers and group plans which do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-94275 Basic Limited Mandate Health Benefit Plan	1/06
GR-94276 Standard Indemnity Plan	1/06
GR-94279 Basic Preferred Provider Plan	1/06
GR-94280 Standard Preferred Provider Plan	1/06
GR-94280-A/AS Standard Preferred Provider Plan	1/06

Recommendation Number 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-113.5, C.R.S., and Colorado Insurance Regulation 4-2-21. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect the right to an independent external review as required by Colorado insurance law.

Issue E8: Failure, in some instances, to provide correct deductibles and out-of-pocket expense information in the Basic and Standard health benefit plan forms.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal, states in part:

> (7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. The commissioner shall survey small group carriers annually to determine the range of health benefits available. *The commissioner shall implement a basic plan that approximates the lowest level of coverage offered in small group health benefit plans.* A basic health benefit plan may be base upon the latest medical evidence. *The commissioner shall implement a standard plan that approximates the average level of coverage offered in small group health benefit plans.* In determining levels of coverage, the commissioner shall consider factors such as coinsurance, copayments, deductibles, out-of-pocket maximums, and covered benefits. The commissioner shall amend the rules as necessary to implement the basic and standard health benefit plans. The rules shall be in conformity with article 4 of title 24, C.R.S., and shall incorporate the following standard health benefit plan design describe in paragraph (a) of this subsection (7.2) and the various options for the basic health benefit plan design described in paragraph (b) of this subsection (7.2). [Emphasis added.]

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S. states in part:

Section 2. Scope and Purpose

> The purpose of this regulation is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard health benefit plans required to be offered to small employer groups and which are used for the purpose of conversion from group coverage as well as to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans* as well as other requirements for small employer carriers. [Emphasis added.]

Section 4. Rules

> A. Plans
>
> 1. <u>Basic Plan.</u> *The form and content of the basic health benefit plan may be one or more of the three main plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options , two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-*

105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan. [Emphasis added.]

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-109, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2008

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan," "Basic HSA Health Benefit Plan," or "Basic HSA Limited Mandate Health Benefit Plan."

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

JANUARY 1, 2008 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS;
INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for service. For the HMO plan, the flat dollar or percentage copay listed is what the *member* will pay.)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN
4. ANNUAL DEDUCTIBLE *(Deductibles do not apply to benefits with flat dollar copays except as noted.)* **a) Individual** **b) Family**	 $ 4,000 $ 12,000
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. The prescription drug deductible and all prescription drug copays are excluded.)* **a) Individual** **b) Family**	 $ 12,000 $ 24,000

3 "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copays, as specified. The deductible and copays for prescription drugs, however, are not applied to the out-of-pocket maximum. Under this basic plan, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

JANUARY 1, 2008 COLORADO STANDARD HEALTH BENEFIT PLANS; INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for service. For the HMO plan, the flat dollar or percentage copay listed is what the *member* will pay.)

STANDARD HEALTH BENEFIT PLAN	STANDARD INDEMNITY PLAN
4. ANNUAL DEDUCTIBLE *(Deductibles do not apply to benefits with flat dollar copays.)* **a) Individual** **b) Family**	 $ 2,000 $ 6,000
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)* **a) Individual** **b) Family**	 $ 4,000 $ 12,000

3 "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copays, as specified. Copays for prescription drugs, however, are not applied to the deductible or out-of-pocket maximum. Under the standard plans, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

It appears that in some instances, the Company is not in compliance with Colorado insurance law in that its Indemnity Plan – Basic Limited Mandate Health Benefit Plan form and Indemnity Plan – Standard Health Benefit Plan form fail to include correct deductible and out-of-pocket limitations as required by Colorado Insurance Regulation 4-6-5. For example, in the basic plan, the Company deductible for an individual is $3,000 and the family amount is $9,000. Regulation 4-6-5 states that these amounts are $4,000 and $12,000 respectively. The standard plan individual deductible is $1,500 and the family limit is $4,500. Colorado Insurance Regulation 4-6-5 states that these limits are $2,000 for an individual and $6,000 for a family.

The Company's basic plan sets out of pocket expenses at $11,000 per individual and $22,000 for a family. Colorado Insurance Regulation 4-6-5 sets these limits at $12,000 per individual and $24,000 for a family. In the Company's standard plan, these limits are $2,500 for an individual and $7,500 for a family. Colorado Insurance Regulation 4-6-5 sets these limits at $4,000 for the individual and $12,000 for the family.

The Company's Indemnity - Basic Limited Mandate Health Benefit Plan form states in part:

> Deductible Amount
>
> The individual deductible amount for you and each of your Dependents each calendar year will be:
>
> a) No Hospital deductible, as applicable, will apply for a newborn child is he/she is discharged with the mother, if the mother is covered under this plan as a Member or Dependent. However, any applicable Hospital deductible will apply if the newborn remains hospitalized or is hospitalized after the mother's discharge, or if the mother is not covered under this plan.
> b) *$3,000 with respect to all other Covered Charges.* [Emphasis added.]
>
> In place of individual deductibles, a family maximum deductible may be applied. When this family maximum is satisfied for a calendar year, Comprehensive Medical benefits will be payable as if the individual deductibles had been satisfied for each person in your family.
>
> *The family maximum deductible with respect to the individual calendar year deductible described above for all persons in the same family (you and your Dependents) each calendar year will be $9,000, but not counting more than $3,000 of such Covered Charges for any one person in the family.* [Emphasis added.]
>
> The deductible does not apply to Preventative Care for your Dependent children.
>
> Benefits Payable
>
> Comprehensive Medical benefits payable for confinement, treatment, or service received each year will be:

a. 50% of each person's Covered Charges in excess of the deductible amount described below *until Out-of-Pocket Expenses, including the deductible are $11,000 per person or $22,000 per family* (you and your Dependents); and [Emphasis added.]

b. 100% of all remaining Covered Charges.

The Company's Indemnity - Standard Health Benefit Plan form states in part:

Deductible Amount

The individual deductible amount for you and for each of your Dependents each calendar year will be:

a. None for Preventive Care for your dependent children; and

b. No Hospital deductible, if applicable, will apply for a newborn child if he/she is discharged with the mother, if the mother is covered under this plan as a Member or Dependent. However, any applicable Hospital deductible will apply if the newborn remains hospitalized or is hospitalized after the mother's discharge, or if the mother is not covered under this plan; and

c. *$1,500 with respect to all other charges*. [Emphasis added.]

In place of individual deductibles, a family maximum deductible may be applied. When this family maximum is satisfied for a calendar year, Comprehensive Medical benefits will be paid as if the individual deductibles had been satisfied for each person in your family.

The family maximum deductible with respect to the individual calendar year deductible described above for all persons in the same family (you and your Dependents) each calendar year will be *$4,500*, but not counting more than *$1,500* of such Covered Charges for any one person in the family.

Benefits Payable

Comprehensive Medical benefits payable for confinement, treatment, or service received each calendar year will be:

a. 80% of each person's Covered Charges in excess of the deductible amount described below until Out-of-Pocket Expenses including the deductible are *$2,500* per person or *$7,500* per family (you and your Dependents);

The following forms do not appear to be in compliance with Colorado insurance law:

Form:		Date
GR-94275	Indemnity Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94276	Indemnity Plan – Standard Health Benefit Plan	1/06

Recommendation Number 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-105, C.R.S., and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect correct deductible and out-of pocket limits as required by Colorado insurance law.

Issue E9: Failure, in some instances, to provide correct information regarding mandated coverage for outpatient physical, occupational, and speech therapy.

Section 10-16-104, C.R.S.**,** Mandatory coverage provisions – definitions, states in part:

(1.7) Therapies for congenital defects and birth abnormalities

(a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday *to the child's sixth birthday.*

(b) *The level of benefits required* in paragraph (a) of this subsection (1.7) *shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy.* Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity. [Emphases added.]

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S. states in part:

Section 2. Scope and Purpose

The purpose of this regulation is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard health benefit plans required to be offered to small employer groups and which are used for the purpose of conversion from group coverage as well as to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans* as well as other requirements for small employer carriers. [Emphasis added.]

Section 4. Rules

B. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three main plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options , two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health

benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-109, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2008

1. *The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity,* preferred provider organization (PPO), and health maintenance organization (HMO) *plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan,"* "Basic HSA Health Benefit Plan," or "Basic HSA Limited Mandate Health Benefit Plan."

3. *The standard health benefit plan for an indemnity,* PPO, and HMO *plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."* [Emphasis added.]

JANUARY 1, 2008 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS; INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for service. For the HMO plan, the flat dollar or percentage copay listed is what the *member* will pay.)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN
21. OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [16]	**50% coinsurance** **(Limited to 25 visits per therapy per year)**

[16] Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, *except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of § 10-16-104, C.R.S., subsections (1.3) and (1.7)* [Emphasis added.].

JANUARY 1, 2008 COLORADO STANDARD HEALTH BENEFIT PLANS; INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for service. For the HMO plan, the flat dollar or percentage copay listed is what the *member* will pay.)

STANDARD HEALTH BENEFIT PLAN	STANDARD INDEMNITY PLAN
21. OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	80% coinsurance **(Limited to 25 visits per therapy per year)**

[20] Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. *The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of § 10-16-104, C.R.S., subsections (1.3) and (1.7).* [Emphasis added.]

It appears that the Company's forms, in some cases, are not in compliance with Colorado insurance law in that the outpatient physical, occupational, and speech therapy provisions appear to cover a combined total of twenty-four (24) outpatient physical, occupational, and speech therapy sessions per year, instead of the required twenty-five (25) sessions of each therapy per year.

The Schedule of Benefits form for the AARP plan offered in Colorado states in part:

Combined Physical, Occupational Therapy and Spinal Manipulation Maximum visits per Calendar Year (GR-9N S-10-95-01)	24 visits	24 visits

In some other cases, the forms appear to provide for a combined total of twenty-five (25) therapy visits per year instead of the required twenty-five (25) visits per therapy per year, and also fail to provide coverage for medically necessary care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday.

The Company's Indemnity and PPO Basic Limited Mandate Health Benefit Plan forms state in part:

PART II – SUMMARY OF BENEFITS

Comprehensive Medical

Durable Medical Equipment ---------- $1,000/Year
Biologically Based Mental Health Care ----- Covered on the same basis as any other physical illness
Physical, Occupational and Speech therapy ---------- *Maximum 25 Visits per year*
[Emphasis added.]

PART IV – DESCRIPTION OF BENEFITS

B – COMPREHENSIVE MEDICAL

Covered Charges

Covered Charges will be the actual cost charges to you or one of your Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Reasonable Charges for:

q. physical, occupational and speech therapy (but not for maintenance therapy after maximum medical improvement is achieved, except for the care and treatment of congenital defects and birth abnormalities *for covered children under five years of age*); and [Emphasis added.]

The Company's Indemnity and PPO Standard Health Benefit Plan forms state in part:

PART II – SUMMARY OF BENEFITS

Comprehensive Medical

Physical, Occupational and Speech therapy----------Maximum 25 Visits per year [Emphasis added.]

PART IV – DESCRIPTION OF BENEFITS

B – COMPREHENSIVE MEDICAL

Covered Charges

Covered Charges will be the actual cost charges to you or one of your Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Reasonable Charges for:

physical, occupational and speech therapy (but not for maintenance therapy after maximum medical improvement is achieved, except for the care and treatment of congenital defects and birth abnormalities *for covered children under five years of age*). [Emphasis added.]

The following forms do not appear to be in compliance with Colorado insurance law:

Form:		Date:
GR-94275	Indemnity Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94276	Indemnity Plan – Standard Health Benefit Plan	1/06
GR-94279	Preferred Provider Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94280	Preferred Provider Plan – Standard Health Benefit Plan	
GR-94280-A.SA	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-9N-S-10-10-05-1054	AARP Essential Premier Health Insurance Plan	No Date

Recommendation Number 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S., and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect correct coverage for occupational, speech, and physical therapy as

required by Colorado insurance law. In addition, the Company should be required to perform a self-audit to correct any claims for therapy services that were incorrectly denied.

Issue E10: Failure, in some instances, to correctly state the annual prescription deductible in the Basic and the prescription drug copayment in the Standard health benefit plan forms.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal, states in part:

> (7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. The commissioner shall survey small group carriers annually to determine the range of health benefits available. The commissioner shall implement a basic plan that approximates the lowest level of coverage offered in small group health benefit plans. A basic health benefit plan may be base upon the latest medical evidence. The commissioner shall implement a standard plan that approximates the average level of coverage offered in small group health benefit plans. In determining levels of coverage, the commissioner shall consider factors such as coinsurance, copayments, deductibles, out-of-pocket maximums, and covered benefits. The commissioner shall amend the rules as necessary to implement the basic and standard health benefit plans. The rules shall be in conformity with article 4 of title 24, C.R.S., and shall incorporate the following standard health benefit plan design describe in paragraph (a) of this subsection (7.2) and the various options for the basic health benefit plan design described in paragraph (b) of this subsection (7.2).

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S. states in part:

Section 2. Scope and Purpose

> The purpose of this regulation is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard health benefit plans required to be offered to small employer groups and which are used for the purpose of conversion from group coverage as well as to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans* as well as other requirements for small employer carriers. [Emphasis added.]

Section 4. Rules

C. Plans

1. <u>Basic Plan.</u> The form and content of the basic health benefit plan may be one or more of the three main plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options , two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health

benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-109, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2008

1. *The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity*, preferred provider organization (PPO), and health maintenance organization (HMO) *plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan,"* "Basic HSA Health Benefit Plan," or "Basic HSA Limited Mandate Health Benefit Plan."

4. *The standard health benefit plan for an indemnity*, PPO, and HMO *plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."* [Emphases added.]

JANUARY 1, 2008 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS; INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for service. For the HMO plan, the flat dollar or percentage copay listed is what the *member* will pay.)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	**BASIC INDEMNITY PLAN**
11. PRESCRIPTION DRUGS [9] **Deductible** *(Must be satisfied prior to application of copays.)*	$100 annual deductible per person
(Deductible and copays do not apply to out-of-pocket maximums.)	$20 copay preferred generic $50 copay preferred rand name $70 copay non-preferred

9 Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health benefit plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits, are not applied to the out-of-pocket maximums. Coverage levels for injectable drugs are based on place of service (e.g., office: included under office visit copay; pharmacy: covered at appropriate copay level based on drug type).

JANUARY 1, 2008 COLORADO STANDARD HEALTH BENEFIT PLANS; INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for service. For the HMO plan, the flat dollar or percentage copay listed is what the *member* will pay.)

STANDARD HEALTH BENEFIT PLAN	STANDARD INDEMNITY PLAN
11. PRESCRIPTION DRUGS [9] *(Copays do not apply to out-of-pocket maximums.)*	$10 copay preferred generic; $ 40 copay preferred brand name $ 60 copay non-preferred [9a]

9 Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits are not subject to the deductible and the copays are not-applied to the out-of-pocket maximums. Coverage levels for injectable drugs are based on place of service (office: included under office visit copay; pharmacy: covered at appropriate copay level based on drug type).

It appears that the Company is not in compliance with Colorado insurance law in that its Indemnity Plan – Basic Limited Mandate Health Benefit Plan form incorrectly assesses the overall comprehensive medical deductible of $3,000 for prescriptions instead of the required $100 annual prescription deductible. The Indemnity Plan – Standard Health Benefit Plan form incorrectly states the co-payments as required by regulation 4-6-5 for prescription drugs received during calendar year 2008.

The Company's Indemnity Basic Limited Mandate Health Benefit Plan form states in part:

PART II – SUMMARY OF BENEFITS

MEDICAL EXPENSE COVERAGE

Deductible Amount

The individual deductible amount for you and for each of your Dependents each calendar year will be:

a. No Hospital deductible, if applicable, will apply for a newborn child if he/she is discharged with the mother, if the mother is covered under this plan as a Member or Dependent. However, any applicable Hospital deductible will apply if the newborn remains hospitalized or is hospitalized after the mother's discharge, or if the mother is not covered under this plan.

b. $3,000 with respect to all other Covered Charges.

PART IV – DESCRIPTION OF BENEFITS

SECTION A –MEDICAL EXPENSE INSURANCE

B – COMPREHENSIVE MEDICAL

Payment Conditions

If you or one of your Dependents receives treatment or service for a sickness or injury, We will pay Comprehensive Medical benefits for Covered Charges:

a. *In excess of the deductible amount*; and [Emphasis added.]
b. At the payment(s) indicated; and
c. To the Maximum Payment Limit;

as described in the Summary of Benefits Section.

Total benefits payable for each person during his or her lifetime will not be more than the Comprehensive Maximum Lifetime Overall (All Causes) Maximum Payment Limit.

Outpatient Prescription Drugs

c. Comprehensive Medical Covered Charges will include charges for outpatient prescription drugs with the benefit payable at 100% of Covered Charges after the applicable copay ($20 preferred generic drugs, $50 preferred brand name drugs, $70 non-preferred). Prescription drugs are those that require a physician's prescription to purchase including contraceptives that require a Physician's prescription. We will also pay Comprehensive Medical benefits for insulin and expendable medical supplies for the treatment of diabetes. [Emphasis added.]

The Company's Indemnity Standard Health Benefit Plan form states in part:

PART II – SUMMARY OF BENEFITS

MEDICAL EXPENSE COVERAGE

Deductible Amount

The individual deductible amount for you and for each of your Dependents each calendar year will be:

c. $1,500 with respect to all other Covered Charges.

PART IV – DESCRIPTION OF BENEFITS

SECTION A –MEDICAL EXPENSE INSURANCE

SECTION B –COMPREHENSIVE MEDICAL

Payment Conditions

If you or one of your Dependents receives treatment or service for a sickness or injury, We will pay Comprehensive Medical benefits for Covered Charges:

a. *In excess of the deductible amount*; and [Emphasis added.]
b. At the payment(s) indicated; and
c. To the Maximum Payment Limit;

as described in the Summary of Benefits Section.

Total benefits payable for each person during his or her lifetime will not be more than the Comprehensive Maximum Lifetime Overall (All Causes) Maximum Payment Limit.

Covered Charges

Covered Charges will be the actual cost charges to you or one of your Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Reasonable Charges for:

n. drugs and medicines requiring a Physician's prescription as described below in this section; and

Outpatient Prescription Drugs

c. *Comprehensive Medical Covered Charges will include charges for outpatient prescription drugs with the benefit payable at 100% of Covered Charges after the applicable copay* ($10 preferred generic drugs, *$30 preferred brand name drugs, $50 non-preferred).* Prescription drugs are those that require a physician's prescription to purchase including contraceptives that require a Physician's prescription. We will also pay Comprehensive Medical benefits for insulin and expendable medical supplies for the treatment of diabetes. [Emphasis added.]

The following forms do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-94275 Indemnity Plan – Basic Limited Mandate Health Benefit Plan	1/06
GR-94276 Indemnity Plan – Standard Health Benefit Plan	1/06

Recommendation Number 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-105, C.R.S., and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect correct information regarding the prescription deductible as required by Colorado insurance law. The Company should be required to conduct a self-audit to correct any charges for prescriptions drugs that were incorrectly applied to the medical deductible under the Basic Limited Mandate Indemnity Plan.

Issue E11: Failure of the Company's forms, in some cases, to reflect the required number of home health care visits.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(8) Availability of hospice care coverage.

(b) Notwithstanding any other provision of the law to the contrary, *no individual or group policy of sickness and accident insurance issued by an insurer subject to the provisions of part 2 of this article* and no plan issued by an entity subject to the provisions of part 3 of this article *which provides hospital, surgical, or major medical coverage on an expense incurred basis shall be sold in this state unless a policyholder under such policy or plan is offered the opportunity to purchase coverage for benefits for the costs of home health services and hospice care which have been recommended by a physician as medically necessary.* Nothing in this paragraph (b) shall require an insurer to offer coverages for which premiums would not cover expected benefits. This paragraph (b) shall not apply to any insurance policy, plan, contract, or certificate which provides coverage exclusively for disability loss of income, dental services, optical services, hospital confinement indemnity, accident only, or prescription drug services.

(d) *The commissioner*, in consultation with the department of public health and environment, *may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care.* Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphases added.]

Colorado Insurance Regulation 4-2-8, Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d), C.R.S., states in part:

Section 2. 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. [Emphasis added]

Section 4. Requirements for Home Health Services

C. Benefits for Home Health Care Services

(2) The policy or certificate may contain a limitation on the number of home health visits, *but no policy offered may provide for fewer than 60 home health visits in any calendar year.* [Emphasis added]

It appears that the Company is not in compliance with Colorado insurance law in that its Summary of Coverage form for individual plans allows for a calendar year maximum of only thirty (30) home health care visits instead of offering the required minimum of sixty (60). In addition, the Company's small group policies do not include any information regarding the required minimum of sixty (60) home health visits an insured may receive in a calendar year.

The Company's Individual Summary of Coverage form states in part:

> **Home Health Care Expenses**
>
> | Preferred Care | Non-Preferred Care |
> |---|---|
> | Benefit:80% | Benefit:50% |
> | *Calendar Year Maximum: 30 visits* | *Calendar Year Maximum: 30 visits* |
>
> [Emphasis added]
> Calendar Year Maximum cross applies to preferred/non preferred care.

The following are the form numbers and health benefit plans which do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-11741 Comprehensive Medical Expense Policy	8/06
GR-11741-SOC-PPO-2,500	8/06
GR-94275 Basic Limited Mandate Health Benefit Plan	Ed. 1/06
GR-94276 Standard Indemnity Plan	Ed. 1/06
GR-94279 Basic Preferred Provider Plan	Ed. 1/06
GR-94280 Standard Preferred Provider Plan	Ed. 1/06
GR-94280-A/AS Standard Preferred Provider Plan	Ed. 1/06

Recommendation Number 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S., and Colorado Insurance Regulation 4-2-8. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect correct coverage for home health care visits as required by Colorado insurance law. In addition, the Company should be required to perform a self-audit to pay any claims for home health services or hospice care that were incorrectly denied.

Issue E12: Failure, in some instances, to allow benefits for covered services based on a licensed provider's status as a family member or a member of the insured's or insured dependent's household.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(7) Reimbursement of providers.

(a) Sickness and accident insurance.

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, *whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.* Nothing in this part 1 or parts 2 or 5 of this article shall preclude an insurance company from setting different fee schedules in an insurance policy for different services performed by different professions, but the same fee schedule shall be used for those portions of health services that are substantially identical although performed by different professions. [Emphasis added]

It appears that in some cases, the Company's health benefit plan forms are not in compliance with Colorado insurance law in that they do not allow benefits for covered services based on a provider's status as a family member or member of a dependent's household.

In the five (5) Basic and Standard policies the Company issues, under the "Limitations" section the forms state:

Limitations

Comprehensive Medical Covered Charges will not include and no benefits will be paid for:

c. the services of any person in your Immediate Family, or any person in your Dependent's Immediate Family. [Emphasis added]

In the Company's GR-9 policy the Company restricts the following:

Home Health Care Expenses

Except as provided above, Home Health Care expenses do not include charges incurred for:

- *Services of a person who usually lives with you or who is a member of your or your wife's or husband's family*. [Emphasis added]

> Outpatient Physical Therapy, Occupational Therapy and Spinal Disorder Treatment Expenses
>
> *Not covered are charges for:*
>
> *Services rendered by a physical or occupational therapist who resides in the Covered Person's home or who is a part of the family of either the Covered person or the Covered person's spouse.*[Emphasis added]

The Company's GR-11741 policy form states:

> Medical Exclusions and Limitations
>
> Charges for services rendered by Relatives
>
> Charges for professional services received from a person who lives in the member's home or who is related to the Member by blood, marriage or adoption.

The following are the form numbers and group plans which do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-94275 Basic Limited Mandate Health Benefit Plan	1/06
GR-94276 Standard Indemnity Plan	1/06
GR-94279 Basic Preferred Provider Plan	1/06
GR-94280 Standard Preferred Provider Plan	1/06
GR-94280-Standard Preferred Provider Plan A/SA	1/06
GR-9 Health Expense Coverage	No date
GR-11741 Comprehensive Medical Expense Policy	8/06

Recommendation Number 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect coverage for services performed by licensed providers who may also be a family member or live in the insured's household as required by Colorado insurance law.

Issue E13: Failure, in some instances, to provide correct information regarding the requirement for precertification.

Section 10-16-705, C.R.S., Requirements for carrier and participating providers, states in part:

(14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:

(a) *A provision that clearly states that the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures,* not with the covered person; [Emphasis added.]

It appears that in some cases, the Company's health benefit plan forms are not in compliance with Colorado insurance law in that they require the member or insured to contact the Company for pre-certification instead of the placing the requirement solely on the contracted provider.

In addition, the Company imposes a penalty on the insured if certification has not been requested and obtained for any service for which preauthorization is required.

In the three (3) Basic and Standard Preferred Provider Plan forms the Company issues, as well as group plan forms GR-11741 and GR-9 the Certification Requirements section states:

Certification of days of confinement can be obtained as follows:

a. If the admission is a Non-Urgent Admission, *you* must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an Emergency or an Urgent Admission, *you, the person's Physician, or the Hospital must get the days certified by calling the number shown on your ID card.* This must be done before the start of a confinement as a full-time inpatient which requires an Urgent Admission; or not later than 48 hours following the start of a confinement as a full-time inpatient which requires an Emergency Admission; unless it is not possible for the Physician to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

b. If, in the opinion of the person's Physician, it is necessary for the person to be confined for a longer time than already certified, *you*, the Physician, or the Hospital may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified. [Emphases added]

The penalty the Company imposes if a hospital confinement is necessary but not pre-certified states:

> *If certification has not been requested and the confinement (or any day of such confinement) is Necessary:*
>
> *Hospital Expenses, up to $400, but not to exceed $2,000 for an individual per calendar year will not be deemed to be Covered Medical Expenses.* [Emphasis added]
>
> Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

The following are the form numbers and group plans which do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-94279 Basic Preferred Provider Plan	1/06
GR-94280 Standard Preferred Provider Plan	1/06
GR-94280-Standard Preferred Provider Plan A/SA	1/06
GR-9 Health Expense Coverage	No date
GR-11741 Comprehensive Medical Expense Policy	8/06

Recommendation Number 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-705, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect that pre-certification for services is the responsibility of the provider as required by Colorado insurance law.

Issue E14: Failure, in some cases, to include correct information regarding the time periods for application of preexisting condition limitations.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(a)(I) If it is a group health benefit plan, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than six months following the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment; except that, for business groups of one, a health benefit plan shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the date of enrollment of the individual in such plan. A group health benefit plan may impose a preexisting condition exclusion or limitation only if such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment; except that a group health benefit plan shall not impose any preexisting condition exclusion in the case of a child that is adopted or placed for adoption before attaining eighteen years of age, or relating to pregnancy.

(II) If it is an individual health benefit plan, or a group health coverage plan to which subparagraph (I) of this paragraph (a) does not apply, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the effective date of coverage and may not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within twelve months.

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule.

It appears that in some cases, the Company's forms are not in compliance with Colorado insurance law in that they include incorrect information regarding the time periods that an individual may be subject to a preexisting condition limitation. The Company's forms indicate that the preexisting condition restrictions

are applicable to covered expenses incurred for twelve (12) months following enrollment, except for a business group of one, which is subject to a six (6) month exclusion. The correct time periods should be six (6) months for groups of 2 – 50 members, and twelve (12) months for business groups of one and individual coverage plans.

The Company's contract forms state, in part, the following:

> **Section C – Preexisting Condition Restrictions**
>
> Covered Medical Expenses do not include expenses incurred:
>
> (i) during the 12 months (6 months as to a business group of one) following your enrollment date; and after the effective date of coverage under this plan.

The Company's AARP Booklet-Certificate states in part:

> For the first 365 days following your Enrollment Date, covered medical expenses do not include any expenses for treatment related to a preexisting condition that manifested itself during the 180 day period immediately preceding your Enrollment Date.

The following are the form numbers and group plans which do not appear to be in compliance with Colorado insurance law:

Form:		Date:
GR-94275	Indemnity Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94276	Indemnity Plan – Standard Health Benefit Plan	1/06
GR-94279	Preferred Provider Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94280	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-94280-A.SA	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-9N-28-019-10054-01-DC	AARP Essential Health Booklet-Certificate	No Date

Recommendation Number 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-118, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect correct preexisting time period limitations as required by Colorado insurance law. In addition, the Company should be required to perform a self-audit to correct any claims that were denied due to improper application of preexisting limitations.

Issue E15: Failure, in some cases, to reflect the correct minimum benefit level for mammography in individual policies.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(4) Low-dose mammography.

(a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women. Routine and diagnostic screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article and shall not be subject to policy deductibles. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. *The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index.* …[Emphasis added]

Colorado Insurance Regulation 4-2-13, Mammography Minimum Benefit Level, promulgated under the authority of §10-1-109,C.R.S., states in part:

II. BASIS AND PURPOSE

The purpose of this regulation is to provide a method for adjusting the minimum mammography benefit which reflects increases and decreases in the consumer price index, as provided in §10-16-104(4)(a), C.R.S.

III. RULE

As of September 1, 1995, the minimum mammography benefit will be $65.37.

Hereafter, on September 1 of each year, every individual and group *sickness and accident insurer,* non-profit hospital, health service corporation and health maintenance organization *subject to §10-16-104(4)(a)* and 10-3-903(2)(h) *C.R.S. shall annually update its mammography benefit to reflect the most recent annual national Consumer Price Index – Urban (CPI-U) published by the U.S. Bureau of Labor and Statistics. This may be done by either revising the*

> *policy forms or evidence of coverage, processing claims at the new benefit level or both.* [Emphasis added]

It appears that in some cases, the Company is not in compliance with Colorado insurance law in that its individual policy forms reflect a benefit level for mammography of sixty dollars ($60) instead of an adjusted amount based on changes to the annual Consumer Price Index – Urban (CPI-U), which is subject to change each year. The Company's individual policy form GR-11741 states in part:

> Benefits are payable on the same basis as any other Sickness except that:
> - any deductible amount will not apply; and
> - *the maximum benefit per screening is the lesser of $60 or the actual charge for such screening.* [Emphasis added]

The following is the form number and plan which does not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-11741 Comprehensive Medical Expense Policy	8/06

Recommendation Number 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-13. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect the correct minimum benefit level for mammography as required by Colorado insurance law. The Company should be required to conduct a self-audit to correct any mammography claims that may have been underpaid as a result of this error.

Issue E16: Failure, in some instances, to proscribe the use of genetic testing in connection with a preexisting condition.

Section 10-3-1104.7, C.R.S., Genetic testing – legislative declaration – definitions – limitations on disclosure of information – liability, states in part:

> (1) The general assembly hereby finds and determines that recent advances in genetic science have led to improvements in the diagnosis, treatment, and understanding of a significant number of human diseases. The general assembly further declares that:
>
> (d) *The intent of this statute is to prevent information derived from genetic testing from being used to deny access to health care insurance*, group disability insurance, or long-term care insurance coverage.
>
> (3) (b) *Any entity that receives information derived from genetic testing may not seek, use, or keep the information* for any nontherapeutic purpose or *for any underwriting purpose connected with the provision of health care insurance, group disability insurance,* or long-term care insurance coverage. [Emphases added]

It appears that in some cases, the Company's forms are not in compliance with Colorado insurance law regarding the use of Genetic testing information, in that they imply that genetic information may be treated as a preexisting condition if there is a diagnosis of the condition related to the information. The Company's Indemnity Plan – Basic Limited Mandate Health Benefit Plan, Preferred Provider Plan – Basic Limited Mandate Health Benefit Plan, Indemnity Plan – Standard Health Benefit Plan, Preferred Provider Plan – Standard Health Benefit Plan and Health Expense Coverage forms state, in part, the following:

> **Section C – Preexisting Condition Restrictions**
>
> A "preexisting condition" is an injury or disease for which a person:
>
> received treatment of services; or
> took prescribed drugs or medicines;
>
> prior to the person's effective date of coverage. *Genetic information will not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information.* Pregnancy will not be treated as a preexisting condition. [Emphasis added.]

The following are the form numbers and plans that do not appear to be in compliance with Colorado insurance law:

Form:		Date:
GR-94275	Indemnity Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94276	Indemnity Plan – Standard Health Benefit Plan	1/06
GR-94279	Preferred Provider Plan – Basic Limited Mandate Health Benefits Plan	1/06

GR-94280	Preferred Provider Plan – Standard Health Benefit Plan	
GR-94280-A.SA	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-9	Health Expense Coverage	No date

Recommendation Number 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-3-1104.7, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to provide correct information regarding the use of genetic testing information as required by Colorado insurance law.

Issue E17: Failure, in some instances, to provide an offer of coverage for overage dependents.

Section 10-16-104.3., C.R.S., Dependent health coverage for persons under twenty-five years of age states:

(1) All individual and group sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of part 2 of this article and all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article that offer dependent coverage shall offer to the parent, for an additional premium if applicable, by rider or supplemental policy provision, the same dependent *coverage for an unmarried child who is under twenty-five years of age,* and is not a dependent as defined by section 10-16-102 if such child: [Emphasis added]

(a) Has the same legal residence as the parent; or

(b) Is financially dependent upon the parent.

(2) The additional premium, if applicable, for a rider or supplemental policy provision offered pursuant to subsection (1) of this section, shall be paid by the parent or the policyholder, at the discretion of the policyholder.

It appears that in some instances, the Company's forms are not in compliance with Colorado insurance law in that they do not reflect an offer of coverage for dependents up to age twenty-five (25).

The Company's Basic Health Benefit Plan forms provide for dependent coverage as follows:

Dependent

A Member's spouse, if that spouse is not in the Armed Forces of any country and not insured under this policy as a Member.

A Member's natural or legally adopted child, if that child:

(1) is not married; and
(2) is not in the Armed Forces of any country; and
(3) is not insured under this policy as a Member; and
(4) is less than 19 years of age.

An adopted child will be considered a dependent on the earliest of;

(1) the date the petition for adoption is filed; or
(2) the date of entry into the Member's home; or
(3) if the child is in the custody of the state, the date of entry of the final decree of adoption.

Coverage for an adopted child will be effective on the date specified above regardless of any preexisting condition. Coverage will above [sic] continuous unless the petition for adoption is denied.

A Member's stepchild or foster child, if that child:

(1) meets the requirements in b. (1), (2), (3), and (4) above; and
(2) receives principal support from the Member; and
(3) is approved by the Company in writing as a dependent; and
(4) lives with the Member, except that a Member's stepchild not living with the Member will be eligible if:

the Member is under a court ordered medical support obligation; and
the child receives principal support from the Member; and
the child is approved by the Company in writing as a dependent.

A child 19 years but *less than 24 years of age* who otherwise qualifies under b. or c. [sic]above, if that child receives principle support from you *and is a Full Time Student.* [Emphasis added]

The Company's GR-11741 form provides the following information regarding dependent coverage in part:

Covered Dependents are the following members of the Policyholder's family who are eligible and accepted under this Policy:

- Any children of the Policyholder or of the Policyholder's covered spouse who are under age 19.

- Any unmarried children of the Policyholder or of the covered spouse who are between the ages of 19 and their 24rd (sic) birthday, provided they are dependent upon them for at least half of their support. If a dependent does not meet the qualifications to remain as a dependent under this Policy, Aetna will issue a separate Policy to that dependent under his/her own social security number.

The following are the form numbers and plans which do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-94275 Basic Limited Mandate Health Benefit Plan	Ed. 1/06
GR-11741 Comprehensive Medical Expense Policy	8/06

Recommendation Number 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104.3, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to include an offer of coverage for dependents to age twenty-five (25) as required by Colorado insurance law.

Issue E18: Failure, in some cases, to accurately reflect the time periods in which claims should be paid.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

…

(4)(a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.* [Emphasis added]

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

It appears that the Company's Basic and Standard Health Benefit Plan forms are not in compliance with Colorado insurance law in that they state that claims will be paid within sixty (60) days of receipt rather than the mandatory time periods outlined in the above statute.

The Company's Basic and Standard policies under Part VIII-CLAIM PROCEDURES state the following:

Time of Payment Claims [sic]

> *Payments due under this Policy will be paid within 60 days of receipt of written proof of loss.* [Emphasis added].

The following are the form numbers and plans which do not appear to be in compliance with Colorado insurance law.

Form:	Date:
GR-94275 Basic Limited Mandate Health Benefit Plan	Ed. 1/06
GR-94276 Standard Indemnity Plan	Ed. 1/06
GR-94279 Basic Preferred Provider Plan	Ed. 1/06
GR-94280 Standard Preferred Provider Plan	Ed. 1/06
GR-94280-A/AS Standard Preferred Provider Plan	Ed. 1/06

Recommendation Number 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-106.5, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect the correct time periods for payment of claims as required by Colorado insurance law.

Issue E19: Failure, in some instances, to include coverage for early intervention services as required under Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1.3) Early intervention services.

(a) As used in this subsection (1.3), unless the context otherwise requires:

(b) (I) *All individual and group sickness and accident insurance policies issued by an entity subject to part 2 of this article on or after January 1, 2008, and all service or indemnity contracts issued by an entity subject to part 3 or 4 of this article on or after January 1, 2008, that include dependent coverage shall provide coverage for early intervention services delivered by a qualified early intervention service provider to an eligible child.* Early intervention services specified in an eligible child's IFSP shall qualify as meeting the standard for medically necessary health care services as used by private health insurance plans. [Emphasis added]

(II) The coverage required by this subsection (1.3) shall be available annually to an eligible child from birth up to the child's third birthday and shall be limited to five thousand seven hundred twenty-five dollars, including case management costs, for early intervention services for each dependent child per calendar or policy year. For policies or contracts issued or renewed on or after January 1, 2009, and on or after each January 1 thereafter, the limit shall be adjusted by the division 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.

(III) Except as provided in paragraph (d) of this subsection (1.3), the coverage shall not be subject to deductibles or copayments, and any benefits paid under the coverage required by this subsection (1.3) shall not be applied to an annual or lifetime maximum benefit contained in the policy or contract. Unless the carrier agrees prior to the provision of early intervention services, a carrier shall not be required to pay a reimbursement rate for early intervention services provided by a nonparticipating provider that exceeds the reimbursement rate allowed for comparable early intervention services provided by a participating provider.

It appears that the Company is not in compliance with Colorado insurance law in that no provisions could be found in the Company's policies that provide for early intervention services for infants and toddlers up to three years of age.

The following are the form numbers and plans which do not appear to be in compliance with Colorado insurance law:

Form:		Date:
GR-94275	Basic Limited Mandate Health Benefit Plan	1/06
GR-94276	Standard Indemnity Plan	1/06
GR-94279	Basic Preferred Provider Plan	1/06
GR-94280	Standard Preferred Provider Plan	1/06
GR-94280-A/AS	Standard Preferred Provider Plan	1/06
GR-9	Health Expense Coverage	No Date
GR-29	Summary of Coverage and Amendments	No Date
GR-11741	Comprehensive Medical Expense Policy	8/06
GR-11741-SOC-PPO-2,500	Summary of Coverage	8/06
GR-9N-S-10-10-05-10054	AARP Essential Premier Health Insurance	No Date

Recommendation Number 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect coverage for early intervention services as required by Colorado insurance law. The Company should also be required to perform a self-audit to correctly pay any claims for early intervention services that were denied in error.

Issue E20: Failure, in some instances, to reflect correct information regarding an insured's option to assign claim benefits directly to providers.

Section 10-16-106.7, C.R.S., Assignment of health insurance benefits, states in part:

(1) (a) *Any carrier that provides health coverage to a covered person shall allow, but not require, such covered person under the policy to assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider as defined in section 10-4-902 (3), an occupational therapist as defined in section 12-40.5-103, C.R.S., or a massage therapist as defined in section 12-48.3-103 (6), C.R.S., also referred to in this section as the "provider", for services provided to the covered person that are covered under the policy.*[Emphasis added]

(b) The covered person may, with or without the agreement of the provider, revoke the assignment. Such revocation shall be in writing and shall be sent to the carrier. The carrier shall send a copy of the revocation to the provider who is the subject of the revocation. The revocation shall be effective when it has been received by both the carrier and the provider and shall only affect those charges incurred after such receipt by both.

(2) (a) When a provider receives an assignment from a covered person, it is the responsibility of the provider to bill the carrier and notify the carrier that the provider holds an assignment on file. The carrier shall honor the assignment the same as if a copy of the assignment had been received by the carrier. Only upon request of the carrier shall the provider be required to give the carrier a copy of the assignment.

(b) The carrier shall honor the assignment and make payment of covered benefits directly to the provider. If the carrier fails to honor the assignment by making payment to the covered person and if the covered person, upon receipt of such payment, fails to pay an amount equivalent to such payment to the provider within forty-five days, the carrier shall be liable for the payment directly to the provider. It shall be the responsibility of the provider to notify the carrier if payment has not been received. In such case, the carrier shall make payment of covered benefits as specified in section 10-16-106.5.

It appears that in some cases, the Company is not in compliance with Colorado insurance law in that the policy language states that benefits will be paid to the insured instead of providing the option of assigning payment directly to a provider.

The Company's Basic and Standard policies state:

Facility of Payment

We will normally pay all benefits to you. However, if the claimed benefits result from a Dependent's sickness or injury, We may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge Us to the full extent of those payments.

a. If payment amounts remain due upon your death, those amounts may, at Our option, be paid to your estate, spouse, child, or parent.

b. If We believe a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, We may pay whoever has assumed the care and support of the person.

In the Company's GR-9 and individual policy GR-11741, there is no information concerning the assignment of benefits to a provider. Therefore, an insured may not be aware of this option to assign claim payments directly to a provider rather than the insured reimbursing providers directly.

The following are the form numbers and plans which do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-94275 Basic Limited Mandate Health Benefit Plan	1/06
GR-94276 Standard Indemnity Plan	1/06
GR-94279 Basic Preferred Provider Plan	1/06
GR-94280 Standard Preferred Provider Plan	1/06
GR-9 Group Health Plan	No Date
GR-11741 Individual Medical Expense	8/06
GR-11741-SOC-PPO-500	8/06
GR-94280-A/AS Standard Preferred Provider Plan	1/06

Recommendation Number 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-106.7, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect correct information regarding assignment of benefits as required by Colorado insurance law.

Issue E21: Failure, in some instances, to provide coverage for mandated organ transplants.

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2. Scope and Purpose

> The purpose of this regulation is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard health benefit plans required to be offered to small employer groups and which are used for the purpose of conversion from group coverage as well as to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans* as well as other requirements for small employer carriers. [Emphasis added.]

Section 4. Rules

D. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three main plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S.* At least one of these three plan design options , two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-109, C.R.S.* [Emphases added.]

BASIC AND STANDARD HEALTH BENEFIT PLAN

POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2008

1. *The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan," "Basic HSA Health Benefit Plan," or "Basic HSA Limited Mandate Health Benefit Plan."*

5. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan." [Emphases added.]

JANUARY 1, 2008 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS; INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for service. For the HMO plan, the flat dollar or percentage copay listed is what the *member* will pay.)

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN
24. ORGAN TRANSPLANTS [18]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.
	50% coinsurance

[18] *Transplants will be covered only if they are medically necessary* and meet clinical standards for the procedure. [Emphasis added.]

JANUARY 1, 2008 COLORADO STANDARD HEALTH BENEFIT PLANS; INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for service. For the HMO plan, the flat dollar or percentage copay listed is what the *member* will pay.)

STANDARD HEALTH BENEFIT PLAN	STANDARD INDEMNITY PLAN
24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.
	80% coinsurance

[22] *Transplants will be covered only if they are medically necessary* and meet clinical standards for the procedure. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its PPO and Indemnity Basic Limited Mandate Health Benefit Plan form and Standard Health Benefit Plans fail to provide for "other single and multi-organ transplants" required by Regulation 4-6-5. In addition, the Company's limitations in these plans regarding animal to human and artificial or mechanical device transplants appear to be overly restrictive since the determination of whether these types of transplants are eligible should be based upon a medical necessity/efficacy standard.

The Company's Basic Limited Benefit form states in part:

Organ Transplants

Comprehensive Medical Covered Charges will include charges for the following Organ Transplants that meet the clinical requirements of the facility where the transplant will be performed:

Heart, lung, heart/lung; and
Liver; and
Kidney, kidney/pancreas; and
Cornea; and
Bone marrow for Hodgkin's aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome (peripheral stem cell support is covered for the same conditions as listed above for bone marrow transplants).

The benefits shall be payable at 50% of the Covered Charges.

Limitations

Comprehensive Medical Covered Charges will not include and no benefits will be paid for: [Emphasis added.]

m. confinement, treatment or service for:

(1) human to human organ transplant *except* for confinement, treatment, service and materials related to the following human-to-human organ or tissue transplant procedures (including charges for organ or tissue procurement), that meet the requirements of the facility where the transplant will be performed: [Emphasis added.]

Heart, lung, heart/lung; and
Liver; and
Kidney, kidney/pancreas; and
Cornea; and
Bone marrow for Hodgkin's aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome (peripheral stem cell support is covered for the same conditions as listed above for bone marrow transplants); or

(2) *animal-to-human organ transplants; or*

(3) *implantation within the human body of artificial or mechanical devices designed to replace human organ(s).* [Emphases added.]

The Company's Standard Health Benefit form states in part:

Organ Transplants

Comprehensive Medical Covered Charges will include charges for the following Organ Transplants that meet the clinical requirements of the facility where the transplant will be performed:

Heart, lung, heart/lung; and
Liver; and
Kidney, kidney/pancreas; and
Cornea; and
Bone marrow for Hodgkin's aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome (peripheral stem cell support is covered for the same conditions as listed above for bone marrow transplants).

The benefits shall be payable at 80% of the Covered Charges.

Limitations

Comprehensive Medical Covered Charges will not include and no benefits will be paid for: [Emphasis added.]

m. confinement, treatment or service for:

(1) human to human organ transplant *except* for confinement, treatment, service and materials related to the following human-to-human organ or tissue transplant procedures (including charges for organ or tissue procurement), that meet the requirements of the facility where the trans-plant will be performed: [Emphasis added.]

Heart, lung, heart/lung; and
Liver; and
Kidney, kidney/pancreas; and
Cornea; and
Bone marrow for Hodgkin's aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome (peripheral stem cell support is covered for the same conditions as listed above for bone marrow transplants); or

(2) *animal-to-human organ transplants; or*

(3) *implantation within the human body of artificial or mechanical devices designed to replace human organ(s).* [Emphases added.]

The following are the form numbers and plans which do not appear to be in compliance with Colorado insurance law:

Form:		Date:
GR-94275	Indemnity Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94276	Indemnity Plan – Standard Health Benefit Plan	1/06
GR-94279	Preferred Provider Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94280	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-94280-A/SA	Preferred Provider Plan – Standard Health Benefit Plan	1/06

Recommendation Number 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect correct coverage for mandated organ transplants as required by Colorado insurance law. The Company should also be required to perform a self-audit to correctly pay any claims that were improperly denied for "other single and multi-organ transplants."

Issue E22: Failure, in some instances, to provide for continuation of insurance for a Member or Dependent merely because they qualify or are eligible for Medicare or Medicaid.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

(1) Group sickness and accident insurance – conversion privileges.

(b) Every group sickness and accident insurance policy included within the provisions of section 10-16-214(1) shall contain a provision which permits every covered employee whose employment is terminated, if the policy remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents. Such provision shall conform to the requirements, where applicable, of subparagraph (XVII) of paragraph (d) and paragraphs (e) and (f) of this subsection (1).

(d) (XIX) The employer shall not be required to *offer* continuation of coverage of any person if such person is covered by Medicare, Title XVIII of the federal "Social Security Act," or Medicaid, Title XIX of the federal "Social Security Act."

(e) (I) Upon the termination of employment of an eligible employee, the death of any such employee, or the change in marital status of any such employee, *the employee or dependent has the right to continue the coverage for a period of eighteen months* after loss of coverage or until such employee or dependent becomes *eligible for other group coverage*. However, should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the eighteen months or until the new plan covers the condition, whichever occurs first. [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its forms provide that a Member or Dependent does not have the right to continuation coverage if the Member or Dependent qualifies or becomes eligible for Medicare or Medicaid benefits.

Colorado insurance law states that an offer of continuation of coverage need not be extended if Medicare or Medicaid already covers the individual when they become eligible for continuation of coverage. However, as neither Medicare nor Medicaid is "group" coverage, the carrier is not allowed to refuse continuation of coverage solely because a Member or Dependent qualifies or becomes eligible for Medicare or Medicaid.

The Company's Basic and Standard policy forms provide for continuation of coverage as follows:

PART III – HOW TO BE INSURED

Section C – CONTINUATION OF COVERAGE

Member or Dependent (State Required – Colorado)

Upon the termination of your employment, your death, or change in marital status or any of your Dependents, you or your Dependents have the right to continue insurance under this policy, if, on the date you or your dependents coverage would otherwise cease:

c. *the person seeking continuation does not qualify for Medicare or Medicaid.* [Emphasis added.]

The Group Accident and Health Insurance Policy form provides for continuation of coverage as follows:

General Information About Your Coverage

Continuation of Coverage

If your coverage would terminate for any reason except:

- Health Expense Coverage discontinues as to your Eligible Class; or
- You fail to make the required contributions;
- *You become eligible for Medicare*; [Emphasis added.]

You may continue any Health Expense Coverage then in force for you and your dependents; but, only if you have been covered under this Plan or under this Plan and any prior plan for at least 6 months in a row.

The following are the form numbers and plans that do not appear to be in compliance with Colorado insurance law:

Form:		Date
GR-29	Group Accident and Health Insurance Policy	7/73
GR-94275	Indemnity Plan – Basic Limited Mandate Health Benefits Plan	1/06
GR-94276	Indemnity Plan – Standard Health Benefit Plan	1/06
GR-94279	Preferred Provider Plan – Basic Limited Mandate health Benefit Plan	1/06
GR-94280	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-94280-A/SA	Preferred Provider Plan – Standard Health Benefit Plan	1/06

Recommendation Number 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-108, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect a continuation of coverage regardless of eligibility for Medicare or Medicaid as required by Colorado insurance law.

Issue E23: Failure, in some instances, to correctly define a significant break in coverage as it pertains to pre-existing conditions exclusions.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) *Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage.* The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule. [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under the authority of Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

Section 5. Rules

B. Colorado law concerning creditable coverage.

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

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

It appears that the Company's individual policy form is not in compliance with Colorado insurance law in that it defines a significant break in coverage as sixty-three (63) days instead of the required ninety (90) days, for the purpose of waiving any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage.

The Company's individual policy GR-11741 states:

Medical Exclusions and Limitations

<u>Pre-existing Conditions</u>

> No payment will be made for services or supplies for the treatment of a Pre-Existing Condition during a period of twelve (12) months following your effective date. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse. *Also, if you were covered under Creditable Coverage as defined by the regulations within 63 days* of becoming covered under this Plan, the time spent under the Qualifying Prior Coverage will be used to satisfy, or partially satisfy, the twelve (12) month period**.** [Emphasis added]

The following are the form numbers and plans which do not appear to be in compliance with Colorado insurance law:

Form:	Date:
GR-11741 Comprehensive Medical Expense Policy	8/06
GR-11741-SOC-PPO-2,500 Summary of Coverage	8/06

Recommendation Number 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect an accurate definition of a significant break in coverage as required by Colorado insurance law.

Issue E24: Failure, in some cases, to reflect mandated coverage for inherited enzymatic disorders.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(1) Newborn children.

(c)(III)(A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic academia; and propionic academia. *Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription*. [Emphasis added]

(B) There is no age limit on benefits for inherited enzymatic disorders specified in sub-subparagraph (A) of this paragraph (III) except for phenylketonuria. *The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.*[Emphasis added]

(C) As used in this subparagraph (III), *"medical foods" means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy,* that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients. [Emphasis added]

(D) Coverage of medical foods, as provided under this subparagraph (III), shall only apply to insurance plans that include an approved pharmacy benefit and shall not apply to alternative medicines. Such coverage shall only be available through participating pharmacy providers. Nothing in this subparagraph (III) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing methods.

It appears that the Company is not in compliance with Colorado insurance law in that some of its contract forms do not provide coverage for medically necessary medical foods as prescribed by a physician for inherited enzymatic disorders.

The following are the form numbers and plans that do not appear to be in compliance with Colorado insurance law:

Form:		Date:
GR-9	Group Accident and Health Insurance Policy	No Date
GR-94279	Preferred Provider Plan – Basic Limited Mandate Health Benefit Plan	1/06
GR-94280	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-94280-A/SA	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-9N-S-10-10-05-10054	AARP Essential Premier Health Insurance Plan	No Date

Recommendation Number 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect coverage for inherited enzymatic disorders as required by Colorado insurance law.

Issue E25: Failure, in some instances, to provide coverage for a newly acquired dependent from the date of birth, adoption, or placement for adoption without preexisting condition or other restrictions unless enrolled within thirty-one (31) days, even when the addition of said dependent would not result in any additional premium to cover the newborn or adopted child.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn children

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period. [Emphasis added.]

(6.5) Adopted child – dependent coverage**.**

(a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, *the entity* shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber *under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber*, regardless of whether adoption of the child is final. [Emphasis added.]

It appears that in some instances, the Company is not in compliance with Colorado insurance law in that its Health Expense Coverage form fails to provide coverage for a newborn or adopted child without restrictions from the date of birth or date of or placement for adoption unless enrolled within thirty-one (31) days of such date even in situations in which no additional premium would be required to add the additional child..

The Company's Certificate and Summary of Coverage includes the following provisions:

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently *elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.*

- Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently *elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.* [Emphases added.]

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- *you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.*

Coverage for the child will become effective on the date the child is placed with you for adoption. *If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.* Emphases added.]

Limitations
Preexisting Conditions

Any limitation as to a preexisting condition will not apply to:

- *A newborn enrolled within 31 days of birth.*
- *A child who is adopted or placed for adoption before attaining 18 years of age and enrolled within 31 days of the adoption or placement for adoption.* [Emphases added.]

The following form number and plan that do not appear to be in compliance with Colorado insurance law:

Form:		Date
GR-9	Health Expense Coverage	No date

Recommendation Number 26:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect accurate information regarding enrollment requirements for a newly acquired dependent as required by Colorado insurance law.

Issue E26: Failure, in some instances, to include accurate information regarding coordination of benefits with Medicare.

Colorado Insurance Regulation 4-6-2, Concerning Group Coordination of Benefits, states, in part:

Section 4. Definitions

H. "Plan" means a form of coverage with which coordination is allowed or required. The definition of plan in the group contract must state the types of coverage that will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

(3) Plan may include:

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

Section 5. Use of Model COB Contract Provision

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

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

E. *No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accord with the rules permitted by this regulation.* [Emphases added.]

Section 6. Rules for Coordination of Benefits

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

(1) Non-Dependent or Dependent

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

(a) Secondary to the plan covering the person as a dependent; and

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

In the review of the Company's policy forms pertaining to the description Medicare Coordination of Benefits by reason of age or disability for eligible employees, it was noted that the Company's description under Part VI – Effect of Medicare On this Plan does not appear to comply with Colorado insurance laws. The language does not accurately describe coordination of benefits between Medicare and the Company plan for employees that are sixty-five (65) years of age.

In addition, the Company's Small Group GR-9 and GR-29 forms do not completely describe eligibility for benefits including the Medicare Secondary Payor Rules (MSR) in their policy forms. Specifically, the certificates include no reference to the different secondary payor rules regarding employers with less than twenty (20) employees, disabled employees and employees with End Stage Renal Disease. Therefore, the language in the Company policies does not appear to adequately reflect or describe coordination of benefits for those eligible for Medicare.

The Company policy language in the Small Group GR-9 and GR-29 contracts state:

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;
  having dropped it;
  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. *This will be done whether or not he or she is entitled to Medicare benefits.* [Emphasis added]
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. *Allowable Expenses will be reduced by any Medicare benefits available for those expenses*. [Emphasis added]

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

The Company's Basic and Standard policies state:

Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and you want Medicare to pay after this Plan, you must enroll for Medicare Parts A and B. If you do not enroll for Medicare when you are first eligible, you or your spouse must enroll during the special enrollment period which applies to each of you when you or your spouse stops being eligible under this Plan

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this plan, whether or not the person has enrolled for Medicare. If Medicare pays first, a covered person should enroll for both Parts A and B of Medicare. Otherwise the expenses may not be covered by the Plan or Medicare.

Medicare and Coordination of Benefits

Under the provision called **When Medicare Pays First**, this Plan only pays benefits after Medicare has paid its benefits.

The following are the form numbers that do not appear to be in compliance with Colorado insurance law:

Form:		Date:
GR-9	Group Accident and Health Insurance Policy	No date
GR-94279	Preferred Provider Plan – Basic Limited Mandate Health Benefit Plan	1/06
GR-94280	Preferred Provider Plan – Standard Health Benefit Plan	1/06
GR-94280-A/SA	Preferred Provider Plan – Standard Health Benefit Plan	1/06

Recommendation Number 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-2. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected all applicable forms to reflect accurate information regarding coordination of benefits with Medicare as required by Colorado insurance law.

Issue E27: Failure, in some instances, to provide information regarding coverage and benefits that is not misleading and/or contradictory in accordance with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (b) False information and advertising generally: *Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public,* in a newspaper, magazine, *or other publication,* or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, *or in any other way,* an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading; [Emphasis added.]

It appears that the Company's GR-9N policy form is not in compliance with Colorado insurance law in that the information contained in the certificate, the schedule of benefits, and the extraterritorial amendment is contradictory and confusing in its overall construction and layout. This makes it difficult, if not impossible, for a person not possessing special knowledge of health care plans to understand what benefits are provided under the plan.

The GR-9N Form, which is constructed on a matrix basis, appears to be unnecessarily misleading to certificate holders. There is no cross-reference mechanism between the certificate, the schedule of benefits, and the extraterritorial amendment. It is difficult to determine whether certain benefits are or are not covered. As an example, the Colorado-mandated coverage for cleft palate is probably included via a quadruple-negative exclusionary language provision in the GR-9N form, in conjunction with the extraterritorial amendment. No cross reference is provided to the certificate, despite the significant clarification in the extraterritorial amendment. This example of the confusing language in the booklet-certificate form states on page 32 in part:

> Unless specifically covered above, *not* covered under this benefit are charges for:
>
> - Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Page 3 of the extraterritorial certificate amendment reads:

> **Cleft Lip and Cleft Palate Rule**
> Coverage for the treatment of a cleft lip or cleft palate is provided as follows:

- Dental related oral surgery of a cleft lip or cleft palate for a child under age 18 is covered as a Type C Service.

Generally, companies use a base policy form with amendments that are easily cross-referenced to the primary form for clarity.

Form:		Date:
GR-9N-CR-1-10054-01-CO	AARP ET Rider	No Date

Recommendation Number 28:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has modified all applicable forms to reflect language that is not misleading and/or contradictory as required by Colorado insurance law.

Issue E28: Failure, in some instances, to include a correct definition of an eligible dependent in accordance with Colorado insurance law.

Section 10-16-102, C.R.S., Definitions, states:

> 14) "Dependent" means a spouse, an unmarried child under nineteen years of age, *an unmarried child who is a full-time student under twenty-four years of age* and who *is financially dependent upon the parent*, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent. [Emphasis added.]

It appears that the Company's forms are not in compliance with Colorado insurance law in that the Booklet-Certificate and ET Certificate Amendment for the AARP Essential Premier Health Insurance plan do not reflect a correct definition of a dependent. There is no requirement in Colorado insurance law for a dependent to be solely dependent on the parent for at least half of their support. Financial dependency is not defined; therefore, any amount of financial dependency for a full-time student would meet the definition in Colorado. There is also no requirement for a full-time student to carry a certain number of credits. As long as the dependent carries enough credits to be considered "full-time" according to the school, (s)he would meet the requirement of the definition.

The AARP Booklet-Certificate states in part:

> **Coverage for Dependent Children**
> To be eligible, a dependent child must be:
>
> - Unmarried; and
> - Up to age 19; or
> - Between the ages of 19-25, as long as he or she is a full-time student at an accredited institution of higher education attends school on a regular basis and *solely depends on you for at least half of their support*. [Emphasis added.]
>
> Newborns of the subscriber's dependent children are not covered under this plan.
>
> Note: Proof of full-time student status is required each year. *This means that the child is enrolled as an undergraduate student with a total course load of least 15 credits or is enrolled as a graduate student with a total course load of at least nine credits.* [Emphasis added.]

The AARP ET Certificate Amendment states in part:

> **Dependents**
>
> You may cover your:
>
> - Wife or husband; and
> - Unmarried children who are under 19 years of age.

> Any other unmarried child under age 24 who goes to school on a regular basis and depends *solely* on you for support will be covered as a dependent. [Emphasis added]

The following are the forms which do not appear to be in compliance with Colorado insurance law:

Form:		Date:
GR-9N 28-019-10054-01-DC	AARP Booklet-Certificate	No Date
GR-9N-CR-1-10054-01	ET Certificate Amendment	No Date

Recommendation Number 29:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-102, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has modified all applicable forms to reflect language that correctly defines an eligible dependent as required by Colorado insurance law.

Issue E29: Failure, in some instances, to correctly and completely define coverage for Cleft Lip and Cleft Palate and to cover all required benefits.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn children.

(c)(II)(A) *With regard to newborn children born with cleft lip or cleft palate or both, there shall be no age limit on benefits for such conditions, and care and treatment shall include to the extent medically necessary: Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; medically necessary orthodontic treatment; medically necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.*

(B) *Cleft lip, cleft palate, or any condition or illness which is related to or developed as a result of the cleft lip or cleft palate shall be considered to be compensable for coverage under the provisions of sub-subparagraph (A) of this subparagraph (II).* [Emphases added.]

During the review of the AARP Essential Premiere Health Benefit Plan forms, it was noted that the coverage provided for cleft lip and cleft palate appear to be incomplete, and do not meet the requirements of Colorado insurance law.

The only coverage for cleft lip and cleft palate appear to be in the ET Amendment Rider issued in conjunction with the AARP Booklet-Certificate and Schedule of Benefits forms provided to Colorado residents in order to bring the booklet-certificate and schedule of benefits into compliance with Colorado laws.

However, as noted below, the benefits provided in the ET Amendment Rider only appear to include "dental related oral surgery" and orthodontic treatment, and the coverage is only provided up to age 18.

Colorado law requires coverage for all medically necessary treatment of cleft lip or cleft palate including both medical and dental types of procedures. In addition, Colorado insurance law states that there shall be no age limit on such treatment of these two conditions.

The language in the Company's AARP ET Amendment Rider reads as follows:

Cleft Lip and Cleft Palate Rule
Coverage for the treatment of a cleft lip or cleft palate is provided as follows:

- Dental related oral surgery of a cleft lip or cleft palate for a child under age 18 is covered as a Type C Service.
- If coverage for **orthodontic treatment** is not otherwise specified in the Booklet Certificate, **orthodontic treatment** of a cleft lip or cleft palate for a child under 18 is covered as a Type C Service.

Form:		Date:
GR-9N-CR-1-10054-01	AARP ET Amendment Rider	No Date

Recommendation Number 30:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has modified all applicable forms to reflect language that correctly and completely defines coverage for Cleft Lip and Cleft Palate as required by Colorado insurance law. The Company should also be required to perform a self-audit to correctly pay any claims that were improperly denied for Cleft Lip or Cleft Palate.

Issue E30: Failure, in some instances, to correctly and completely define eligibility for a second level review in accordance with Colorado insurance law.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Benefit Denial, promulgated and adopted under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

> Section 3 Applicability and Scope
>
> *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, 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. 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. [Emphasis added.]

In the review of policy forms and Certificate Amendments it was noted that the Company incorrectly stated that only group health claims are eligible to file a Second Level Appeal Review. This does not appear to comply with Colorado Insurance Regulation 4-2-17 which states that this process applies to all health coverage plans.

In the Company's GR-9N policy and Certificate amendment (including AARP group policy) the Company states:

> **Second Level Appeal Review- (Applies *Only* to Group Health Claims)** [Emphasis added].

Therefore, a policyholder under an association health plan may not be aware of their rights to be eligible to file a Second Level Appeal Review as required under Colorado insurance law.

The following forms do not appear to be in compliance with Colorado insurance law:

Form	Date
GR-9N CO MC $500 90/60 $15/$30-(2007)-COM0010060107001 56320	No Date
GR-9N-CR-1-10054-01-CO AARP ET Amendment Rider	No Date

Recommendation Number 31:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has modified all applicable

forms to reflect language that correctly and completely defines eligibility for a second level review as required by Colorado insurance law.

Issue E31: Failure, in some instances, to include mandated coverage for hospitalization and general anesthesia for dental procedures for dependent children in accordance with Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(12) Hospitalization and general anesthesia for dental procedures for dependent children.

(a) *All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article* and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article except supplemental policies that cover a specific disease or other limited benefit *shall provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child,* as dependent is defined in section 10-16-102 (14), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

(I) The child has a physical, mental, or medically compromising condition; or

(II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or

(III) The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or

(IV) The child has sustained extensive orofacial and dental trauma.

[Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that the forms that make up the AARP Essential Premier Health Insurance plan do not include the mandated coverage for hospitalization and general anesthesia for dental procedures for dependent children as required.

Form:		Date:
GR-9N-02-005-10054-01-DC	AARP Essential Premier Booklet-Certificate	No Date
GR-9N-S-10-10-05-10054	AARP Essential Premier Schedule of Benefits	No Date
GR-9N-CR-1-10054-01-CO	AARP ET Amendment Rider	No Date

Recommendation Number 32:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has modified all applicable forms to reflect the mandatory coverage for hospitalization and general anesthesia for dental procedures for dependent children as required by Colorado insurance law.

RATING

Issue F1: Failure to submit a rate filing for the AARP medical expense insurance plan prior to using the rates and marketing the plan.

Section 10-16-107, C.R.S., Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain, states in part:

(1) Rates for any sickness, accident, or health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, enrollee, subscriber, or member in Colorado, by an insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 or 4 of this article shall not be excessive, inadequate, or unfairly discriminatory. To assure compliance with the requirements of this section that rates are not excessive in relation to benefits, the commissioner shall promulgate rules to require rate filings and, as part thereof, may require the submission of adequate documentation and supporting information including actuarial opinions or certifications and set loss ratios for loss ratio guarantees. *Rate filings for insurance regulated under parts 1 to 4 of this article shall be filed electronically in a format made available by the division, unless exempted by rule for an emergency situation as determined by the commissioner.* A rate filing summary for insurance regulated under parts 1 to 4 of this article shall be posted on the division's internet site in order to provide notice to the public. Nothing in this section shall be construed to limit the right of the public to inspect a rate filing and any supporting information pursuant to part 2 of article 72 of title 24, C.R.S., nor to impair the commissioner's ability to review rates and determine that the rates are not excessive, inadequate, or unfairly discriminatory. [Emphasis added.]

Colorado Insurance Regulation 4-2-11, Rate Filings and Annual Report Submissions Health Insurance, promulgated pursuant to the authority of §§ 10-1-109, 10-3-1110, 10-16-107(1), 10-16-107(1.5), and 10-16-109, C.R.S., states in part:

Section 5 General Rate Filing Requirements

A. General Requirements

1. Required Submissions:

a. *All companies must submit rate filings whenever the rates charged new or renewal policyholders or certificateholders differ from the rates on file with the Division of Insurance.* 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.

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

It appears the Company is not in compliance with Colorado insurance law in that it failed to file rates for the AARP health benefit program as required by Colorado Insurance Regulation 4-2-11 prior to using these rates in conjunction with marketing of the AARP health plan. During the review, it was noted that the Company submitted a rate filing for this product as part of a forms filing. However, the Division did not accept that rate filing as rate filings cannot be combined with a form filing or other types of submissions. Therefore, it appears that the Company used unfiled rates during the period under review.

Recommendation Number 33:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-107, C.R.S., and Colorado Insurance Regulation 4-2-11. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its rate filing procedures to ensure that rates are filed for all products prior to marketing them as required by Colorado insurance law.

NEW BUSINESS APPLICATIONS & RENEWALS

Issue G1: Failure of the Company's small group renewal forms, to provide accurate information regarding dependent coverage.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(b) False information and advertising generally: *Making, publishing, disseminating, circulating, or placing before the public,* or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or *in the form of a notice,* circular, pamphlet, letter, or poster, or over any radio or television station, or *in any* other way, an advertisement, announcement, or statement containing any assertion, representation, or *statement with respect to the business of insurance,* or with respect to any person in the conduct of his insurance business, *which is untrue, deceptive, or misleading;* [Emphasis added.]

Section 10-16-104.3, C.R.S., Dependent health coverage for persons under twenty-five years of age states in part:

(1) All individual and group sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of part 2 of this article and all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article that offer dependent coverage shall offer to the parent, for an additional premium if applicable, by rider or supplemental policy provision, the same dependent *coverage for an unmarried child who is under twenty-five years of age,* and is not a dependent as defined by section 10-16-102 if such child: [Emphasis added]

(c) Has the same legal residence as the parent; or

(d) Is financially dependent upon the parent.

(2) The additional premium, if applicable, for a rider or supplemental policy provision offered pursuant to subsection (1) of this section, shall be paid by the parent or the policyholder, at the discretion of the policyholder.

In the review of small group renewal notices it was noted that the Company restricts dependent coverage to dependents under age twenty-four (24) for groups that are written as part of a trust. Although the Company indicated in its response to this issue that it does not write any Colorado small group medical plans through a trust, it is unlikely that many members would know whether or not their plan was written as part of a trust. Therefore, including this information in renewal notices provided to Colorado small group members is deceptive and misleading. The Company's renewal notices state that non-student dependents up to age twenty-four (24) must obtain their own stand alone policy instead of allowing them to remain on the parent's policy.

Recommendation Number 34:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-104.3, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence that it has corrected its Small Group renewal notices to reflect correct information regarding dependent coverage as required by Colorado insurance law.

CANCELLATIONS/NON-RENEWALS/DECLINATIONS/RESCISSIONS

Issue H1: Failure to reflect the full definition of a significant break in coverage in the certificate of creditable coverage notice forms.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule*. [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, states in part:

Section 4. Definitions

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

Section 5. Rules

B. Colorado law concerning creditable coverage.

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

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

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

4. Certifying creditable coverage

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

It appears the Company's certificate of creditable coverage notice form is not in compliance with Colorado insurance law in that the form sent to members of cancelled small groups and individuals titled "Certificate of Prior Health Coverage" does not reflect the full definition of "significant break in coverage" as provided in Section 4. A. of Colorado Insurance Regulation 4-2-18. Such full definition is required under Section 5. B. 4. The Company's definition does not state that if an insured leaves Colorado, a significant break in coverage may consist of as few as sixty-three (63) days.

The Company's Certificate of Prior Health Coverage states:

IMPORTANT NOTICE

This Certificate is proof of your prior health insurance coverage as required under the Federal Health Insurance Portability and Accountability Act ("HIPAA") and state law. Aetna and other health insurance carriers use this certificate to determine if an individual has had a "significant break in coverage." Anyone with a significant break in coverage may be subject to a pre-existing condition limitation. A "significant break in coverage" means a period of consecutive days during which the individual does not have any creditable coverage. Waiting periods or affiliation periods are not taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Divisions [sic] of Insurance, a significant break in coverage consists of more than 90 consecutive days.

Recommendation Number 35:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its Certificate of Creditable Coverage Notice to reflect the definition of a significant break in coverage as required by Colorado insurance law.

Issue H2: Failure, in some instances, to provide written notice of the availability of small group coverage to business groups of one upon denial of coverage under an individual plan.

Section 10-16-105.2, C.R.S., Small employer health insurance availability program, states in part:

(1)(c)(I) The provision of this article concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole-proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met:

(C) If the carrier rejects an application from a business group of one self-employed person and the carrier does business in both the individual and small group markets, the carrier shall notify the applicant of the availability of coverage through the small group market and of the availability of small group coverage through the carrier. [Emphasis added]

Colorado Insurance Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated under the authority of §§ 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 10-16-108.5(8) and 10-16-109, C.R.S., states in part:

5. Rules

A. An individual health benefit plan marketed and/or newly issued on or after October 1, 2004, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all of the following conditions:

…

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

It appears the Company is not in compliance with Colorado insurance law in that, in some instances, it failed to provide the mandated written notice of the availability of coverage under a small group plan to applicants who were rejected for coverage under an individual plan and who appeared to qualify as a Business Group of One (BG1).

New Business Application Declinations
January 1, 2008-December 31, 2008

Population	Sample	Number of Exceptions	Percentage
421*	86	19	22%

*The total population for individual applications was 594 less 173 applications for AARP business which were sampled separately.

The examiners reviewed a sample of eighty-six (86) files of individual new business declinations from a population of 421. In nineteen (19) or 22% of the files reviewed, the Company failed to provide the required notifications to individual applicants who were denied coverage under an individual plan, and who self-identified at the time of application as being a Business Group of one (BG1).

Recommendation Number 36:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section §10-16-105.2, C.R.S., and Colorado Insurance Regulation 4-2-19. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its procedures to ensure that all applicants who are declined coverage under an individual plan and who appear to be Business Groups of one (BG1) receive notice of the availability of small group coverage as required by Colorado insurance law.

Issue H3: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plans.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states in part:

(4) Special provisions for small group health benefit plans

(a) Effective January 1, 1995, each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). *Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel*. [Emphasis added.]

(c) Each small employer carrier shall offer the choice of a basic or standard health benefit plan to any individual who loses nexus to existing small group coverage; except that:

(I) If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of this paragraph (c) shall not apply to such an individual; and

(II) If an individual lost nexus to group coverage for fraud or abuse in procuring or utilizing coverage, then the provisions of this paragraph (c) shall not apply to such an individual.

In the review of small group terminations it was noted that the Company did not offer coverage to individuals whose employers' policies were cancelled due to non payment of premium or cancelled by the employer without a stated reason. There was no indication in any of the cited cases that the group's coverage had been replaced with another group plan or that an offer of Basic or Standard coverage was made to individual employees of the terminated plan.

Small Group Terminations

Population	Sample Size	Number of Exceptions	Percentage of Sample
700	113	36	32%

The examiners reviewed a sample of 113 files that were randomly selected from a population of 700 small groups whose coverage was canceled during the exam period of January 1, 2008 through December 31, 2008. It appears that the Company is not in compliance with Colorado insurance law in that in thirty-six (36) cases, upon termination of the group policy the Company failed to offer members of the terminating small group a choice of the Basic or Standard Health Benefit Plans as required by Colorado insurance law.

Recommendation Number 37:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-108, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its procedures to ensure that an offer of either the Basic or Standard health benefit plans is made to all employees of terminated groups whose coverage was not replaced with other group coverage as required by Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the carrier's standard claim form with all required fields completed with correct and complete information in accordance with the carrier's published filing requirements. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.* [Emphasis added.]

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphasis added.]

Using ACL™ software, the examiners reviewed the entire population of 428,769 claims provided by the Company for timeliness in adjudicating. It appears that the Company is not in compliance with Colorado insurance law in that:

CLEAN CLAIMS PROCESSED OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
18,727*	109	79	72%

(*<1% of all paid and denied claims.)

Seventy-nine (79) of 109 claims randomly selected from the total population of 18,727 electronic claims adjudicated more than thirty (30) days after receipt appeared to be clean claims that were not paid, denied or settled within the required time frame.

In these seventy-nine (79) instances, the examiner's review indicated that the claims noted as exceptions appeared to meet the definition of a "clean" claim as set forth in §10-16-106.5 (2), C.R.S., contrary to any system coding by the Company. Claims that were legitimately pended due to additional information being requested in a timely and/or proper manner were not included as exceptions, nor were instances where a claim settlement check was reissued to the provider/ member.

CLEAN CLAIMS PROCESSED OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,465*	108	47	44%

(*<1% of all paid and denied claims.)

Forty-seven (47) of 108 non-electronic claims randomly selected from the total population of 2,465 non-electronic claims adjudicated more than forty-five (45) days after receipt appeared to be clean claims that were not paid, denied or settled within the required time frame.

In some cases, the examiner's review indicated a claim was determined unclean by the Company in error because the information requested in a pending notice was provided with the original claim submission. In other cases there was no copy of a request for additional information sent to the member or the provider. In still other cases when it appeared additional information was needed and there was no pending notice requesting information, the Company advised the examiners there was no pending notice as no further information was required to adjudicate the claim. All those files are included as exceptions in this comment form.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
7,448*	109	104	95%

(*<1% of all paid and denied claims.)

The examiners identified 104 out of the 109 claims randomly selected from the total population of 7,448 claims adjudicated more than ninety (90) days after receipt that were not paid, denied or settled as required by Colorado insurance law. There was no indication in the claim records that any of the cited claims involved fraud. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) calendar days of receipt.

Recommendation No. 38:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied, or settled within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay correct interest and/or penalty on claims not paid, denied, or settled within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.* [Emphasis added.]

(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty* percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* [Emphasis added.]

*Note that this penalty was ten (10) percent until it was increased to twenty (20) percent per statute. See L. 2008: (5)(b) amended, p. 2174, §7, effective August 5, 2008.

Using ACL™ software, the examiners reviewed the entire population of 428,769 claims provided by the Company. It appears that the Company is not in compliance with Colorado insurance law in that:

CLEAN CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
18,727*	109	10	9%

(<1% of all paid and denied claims.)

The Company failed to pay a ten percent (10%) penalty on ten (10) claims submitted electronically that were not paid, denied, or settled within thirty (30) days where interest was determined to be due.

PAID CLAIMS OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
7,448*	109	26	24%

(<1% of all paid and denied claims.)

The Company failed to pay a ten percent (10%) penalty on seven (7) claims adjudicated prior to August 5, 2008, and a twenty percent (20%) penalty on nineteen (19) claims adjudicated on or after August 5, 2008, of the total amount ultimately allowed on the claim to the insured or health care provider on the ninety-first (91st) day on each of the twenty-six (26) claims not paid or settled within ninety (90) days.

Recommendation No. 39:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that interest and/or penalties are paid for all claims not paid or settled within the time periods required by Colorado insurance law. The Company should be required to conduct a self-audit to ensure that all past due interest and penalties are paid.

Issue J3: Failure, in some instances, to request additional information required for the adjudication of unclean claims in accordance with Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration states, in part:

> (4)(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmission of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphasis added.]

Colorado Insurance Regulation 4-2-24, Concerning Clean Claim Requirements for Health Carriers states, in part:

Section 6. Additional Information

> A. A claim with all required fields is not considered "clean" if additional information is needed in order to adjudicate the claim. Carrier 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 liability to be made. *When additional information is required the carrier shall make the specific request in writing within thirty calendar days after receipt of the claim form.* If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. *The specific information requested shall be requested within 30 calendars days after receipt of the clam form and identified for the provider upon request.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that:

CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
18,727*	109	25	23%

Twenty-five (25) of the 109 electronic claim files randomly selected for review from the total population of 18,727 electronic claims processed beyond 30 days appeared to be unclean claims for which additional information was required for the Company to determine its liability. However:

- Two (2) files did not contain any documentation that a written request for additional information and/or an explanation of what additional information was needed to adjudicate the claim was sent to the Provider and/or the Member for the sampled claim;

- In four (4) files, the written request for additional information needed to adjudicate the claim was requested on a prior claim instead of the sampled claim and/or the Company was in possession of said information at the time it adjudicated the sampled claim; and

- In nineteen (19) files the written request for additional information needed to adjudicate the claim was requested on a different claim, instead of correctly identifying the specific information needed to resolve the sampled claim.

CLAIMS OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
7,448*	108	11	10%

Eleven (11) of the 108 non-electronic over 45 day claim files randomly selected for review from the total population of 2,465 claims over 45 days appeared to be unclean claims for which additional information was required for the Company to determine its liability. However:

- In one (1) file, the request for additional information was made more than thirty (30) calendar days after the Company's receipt of the claim, and

- In ten (10) files the written request for additional information needed to adjudicate the claim referenced a previous request for information on a different claim, instead of correctly identifying the specific information needed to resolve the current claim. Six (6) of the ten (10) stated only that information had been previously requested and the current claim would be considered when the previously requested information was received. That statement was not specific as to what information was needed. Three (3) files referred to pre-existing condition concerns and information previously requested from a provider or from the member. In addition, two (2) of the notices from other claims were not requests for additional information but were notices that the allowed benefits under that claim had been applied to the deductible.

Colorado insurance law requires carriers to request additional information needed to adjudicate a claim within thirty (30) calendar days after receipt of the claim, to make such request in writing and to include a full explanation in that request of what is needed to resolve that claim. Requests that refer to previous requests made on other claims do not meet the requirement for the specific written notice required for each claim.

Recommendation No. 40:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-106.5, C.R.S and Colorado Insurance Regulation 4-2-24. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that unclean claims requiring additional information to adjudicate are handled in accordance with Colorado insurance law.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure, in some instances, to comply with the notification requirements pertaining to an external review.

Colorado Insurance Regulation 4-2-21, External Review Of Benefit Denials Of Health Coverage Plans, promulgated under the authority of §§10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states in part:

Section 8 Standard External Review

A. Carrier Requirements.

1. Except as provided in Paragraph 2. of this subsection A., the carrier, upon receipt of a complete request for an external review pursuant to Section 6. of this regulation, *shall deliver a copy of the request to the Commissioner of Insurance within two (2) working days*.

B. Division of Insurance requirements.

2. After notice from the Commissioner pursuant to Paragraph 1. of this subsection B., *the carrier shall notify within two (2) working days the covered person or the designed representative, electronically, by facsimile, or by telephone, followed* by a written confirmation. *The notice shall include a written description of the independent external review entity that the Commissioner has selected to conduct the external review and information regarding how the covered person or the designated representative may provide the Commissioner with documentation regarding any potential conflict of interest of the independent external review entity as described in Section 12 of this regulation*.

C. Carrier requirements to provide documentation of information

1. Within six (6) working days from the date the carrier receives notice from the Commissioner pursuant to Paragraph 1. of Section 8.B., the carrier shall deliver to the assigned independent external review entity the following documents and information considered in make the carrier's adverse determination including:

a. Any and all information submitted to the carrier by a health care professional or the covered person or designated representative in support of the request for coverage under the health coverage plan's procedures;

b. Any and all information used by the plan 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 letter issued by the plan 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.

H. Independent external review entity notice requirements.

4. *Upon carrier's receipt of the independent external review entity's notice of a decision pursuant to Paragraph 1. of this subsection H. reversing the its adverse determination, the carrier shall approve the coverage that was the subject of the carrier's adverse determination.* For concurrent and prospective reviews, the carrier shall approve the coverage within one (1) working day. For retrospective reviews, the carrier shall approve the coverage within five (5) working days. The carrier shall provide written notice of the approval to the covered person or the designated representative within one (1) working day of the carrier's approval of coverage. The coverage shall be provided subject to the terms and condition applicable to benefits under the health coverage plan. [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that its external review files, in some instances, did not meet the notification requirements set forth in Colorado Insurance Regulation 4-2-21.

INDEPENDENT EXTERNAL REVIEWS

Population	Sample	Number of Exceptions	Percentage of Sample
10	10	10	100%

The examiners reviewed the Company's entire population of twelve (12) external review files. Of those files, one (1) was determined to be a Colorado resident covered under a Texas contract, and another file was subsequently determined to be a self-insured case. These two (2) files were removed from consideration, making the effective population of cases reviewed ten (10) files. All ten (10) of the files reviewed were standard external reviews requests. Of these ten (10) files, it was determined that:

1) In two (2) of the files reviewed, there was no record found of the Company's delivery of notice of an external review request to the Division of Insurance.

2) In ten (10) of the files reviewed, there was no record found of the Company's electronic (including via facsimile) or telephonic notification to the covered person/designated representative of the External Review entity assigned.

3) In three (3) of the files reviewed, there was no record found of the Company's follow-up written notification to the covered person/designated representative of the External Review entity assigned along with instructions on how to provide documentation regarding potential conflicts of interest of the review entity.

4) In one (1) of the files reviewed, there was no record found of the Company providing the external review entity with the required documentation and records.

5) In one (1) of the files reviewed, there was no record found of the Company's notification to the covered person or their designated representative of the approval of the appealed coverage as determined by the external review entity.

Recommendation Number 41:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-21. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its procedures to ensure that all required notifications are sent to covered persons or their representatives concerning independent external reviews as required by Colorado insurance law.

Issue K2: Failure, in some cases, to ensure that the majority of the appeal review committee was comprised of health care professionals with the appropriate expertise in relation to the case for second level reviews.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 4. Definitions

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

Section 11. Voluntary Second Level Review

F. Procedures

1. With respect to a voluntary second level review of a first level appeal decision, the denial shall be reviewed by a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, *who have appropriate expertise in relation to the case presented by the covered person*… [Emphasis added.]

VOLUNTARY SECOND LEVEL REVIEWS

Population	Sample	Number of Exceptions	Percentage of Sample
9	9	6	67%

The examiners reviewed the entire population of nine (9) voluntary second-level utilization review appeal files initiated by "covered persons" or their representative(s) during the examination period of January 1, 2008 to December 31, 2008.

It appears that the Company did not meet the requirements of Colorado insurance law in that in six (6) of the nine (9) of the voluntary second-level review decisions reviewed, the Company failed to ensure that the majority of the review committee was comprised of health care professionals with the appropriate expertise in relation to the case being presented by the covered person and/or their representative(s). It appears that the use of case managers and appeal analysts do not meet the criteria of "health care professionals who have appropriate expertise in relation to the case presented" as outlined in the regulation.

Recommendation Number 42:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its procedures to ensure that the majority of reviewers of second level utilization reviews are comprised of health professionals with appropriate expertise in relation to the case presented as required by Colorado insurance law.

Issue K3: Failure, in some cases, to provide the names, titles and qualifying credentials of participants in second level reviews.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 11. Voluntary Second Level Review

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

(1) *The names, titles and qualifying credentials of the review panel…* [Emphasis added]

The examiners reviewed the entire population of nine (9) voluntary second-level utilization review appeal files initiated by "covered persons" or their representative(s) during the examination period of January 1, 2008 to December 31, 2008.

VOLUNTARY SECOND LEVEL REVIEWS

Population	Sample	Number of Exceptions	Percentage of Sample
9	9	3	33%

It appears that the Company did not meet the requirements of Colorado insurance law in that in three (3) of the nine (9) voluntary second-level review decisions reviewed, the Company's decision notification letter and/or attachment provided to the covered person and/or their representative(s), did not contain the names, titles or qualifying credentials of the members of the review panel.

Recommendation Number 43:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its procedures to ensure that the names, titles and qualifying credentials of the members of all second level utilization review panels are provided to covered persons as required by Colorado insurance law.

Issue K4: Failure, in some cases, to provide all required disclosures to covered persons or their representatives for second level reviews.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Benefit Denial, promulgated and adopted by the Commissioner of Insurance under authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 11. Voluntary Second Level Review

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

2. Notice Requirements. The notice to the covered person of the review date shall include:

a. The right of the covered person to present written comments, documents, records and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting.

b. The right of the covered person to receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable.

c. The responsibility of the covered person to submit a copy of the materials that the covered person plans to present or have presented on his or her behalf at the review to the health carrier at least five (5) days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided to the carrier when practicable.

d. The responsibility of the covered person to, within seven (7) days in advance of the review, inform the carrier if the covered person intends to have an attorney present to represent such person's interest. If the covered person decides to have an attorney present after the seven-day deadline, notice will be provided to the carrier when practicable.

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

f. The health carrier shall use this notification to advise the covered person that that plan shall make either an audio or video recording of the review unless neither the covered person nor the health carrier wants the recording made. The notice shall advise

that this recording shall be made available to the covered person and 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 meeting. Whenever a covered person has requested the opportunity to appear in person, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate, at the health carrier's expense, by telephone conference call. A carrier may also offer video conferencing or other appropriate technology.

VOLUNTARY SECOND LEVEL REVIEWS

Population	Sample	Number of Exceptions	Percentage of Sample
9	9	3	33%

The examiners reviewed the entire population of nine (9) voluntary second-level review files initiated by "covered persons" or their representative(s) and/or conducted during the examination period.

It appears that the Company did not meet the requirements of Colorado insurance law in that in three (3) of the nine (9) of the files reviewed, the Company failed to meet the one or more of the disclosure requirements set forth in Colorado Insurance Regulation 4-2-17 in their written correspondence to the covered person and/or their representative.

Recommendation Number 44:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its procedures to ensure that all required disclosures are provided to covered persons or their representatives concerning second level utilization reviews as required by Colorado insurance law.

Issue K5: Failure, in some cases, to include the name, title and qualifying credentials of the physician who evaluated the appeal and the qualifying credentials of the clinical peer(s) with whom the physician consulted in first level review decision letters.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 10. First Level Review

I. The decision issued pursuant to Subsection G, shall set forth in a manner calculated to be understood by the covered person:

(2) *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.* [Emphasis added]

First Level Reviews

Population	Sample	Number of Exceptions	Percentage to Sample
104	79	45	57%

The examiners reviewed a sample of seventy-nine (79) first-level utilization review appeal files initiated by "covered persons" or their representative(s) during the examination period It appears that the Company did not meet the requirements of Colorado insurance law in that in forty-five (45) of the seventy-nine (79) first-level utilization review decisions, the Company's decision notification letter and/or attachment provided to the covered person and/or their representative(s), did not contain the names, titles or qualifying credentials of the physician that evaluated the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consulted, as set forth in Colorado Insurance Regulation 4-2-17.

Recommendation Number 45:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its procedures to ensure that the name, title and qualifying credentials of physicians and clinical peers is included in the decision notifications sent to covered persons of all first level utilization reviews as required by Colorado insurance law.

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Examination Report Submission

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