SECOND MODIFIED MARKET CONDUCT EXAMINATION REPORT
Dated March 4, 2011

COVERING THE TIME PERIOD OF JULY 1, 2007 THROUGH JUNE 30, 2009

HUMANA INSURANCE COMPANY
1100 Employers Blvd
De Pere, WI 54344

NAIC Company Code: 73288
NAIC Group Code: 119

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

HUMANA INSURANCE COMPANY
1100 Employers Blvd
De Pere, WI 54344

MARKET CONDUCT EXAMINATION REPORT
DATED MARCH 4, 2011
COVERING THE TIME FRAME OF JULY 1, 2007 THROUGH JUNE 30, 2009

Examination Performed by:

State Market Conduct Examiners

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March 4, 2011

The Honorable John J. Postolowski
Interim Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Postolowski:

This market conduct examination of Humana Insurance Company ("HIC") was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205 and 10-3-1106, C.R.S., which authorize the Commissioner of Insurance ("Commissioner") to examine insurance companies. HIC's records were examined at its branch office located at 1100 Employers Boulevard, De Pere, WI 54344. The market conduct examination covered the period from July 1, 2007, through June 30, 2009.

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

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COMPANY PROFILE

Humana Inc. ("Humana"), is headquartered in Louisville, KY, and has approximately 10.3 million medical members and approximately 7.2 million specialty-benefit members. Humana is a full-service benefits solutions company, offering a wide array of health and supplemental benefit plans for employer groups, government programs and individuals.

Humana, over the last several years, has experienced a shift in its small group membership from Humana Insurance Company (HIC) to Humana Health Plan, Inc. (HHP). The shift is attributable to launching new HMO OA and NPOS OA plans in mid to late 2007 that were able to take advantage of improved HMO contracted rates. The improved HHP contracted rates resulted in premium savings when compared to HIC plans with similar benefits. The resulting pricing differential shifted new business sales from HIC to HHP. This combined with migration of in force membership at renewal has shifted a larger proportion of HIC's membership to HHP.

HIC was initially licensed and began operation in Colorado on July 25, 1987. During the exam period of July 1, 2007 through June 30, 2009, HIC was licensed in forty-nine (49) states (NY not included) and the District of Columbia. HIC noted that there was not active business in all states in which it was licensed.

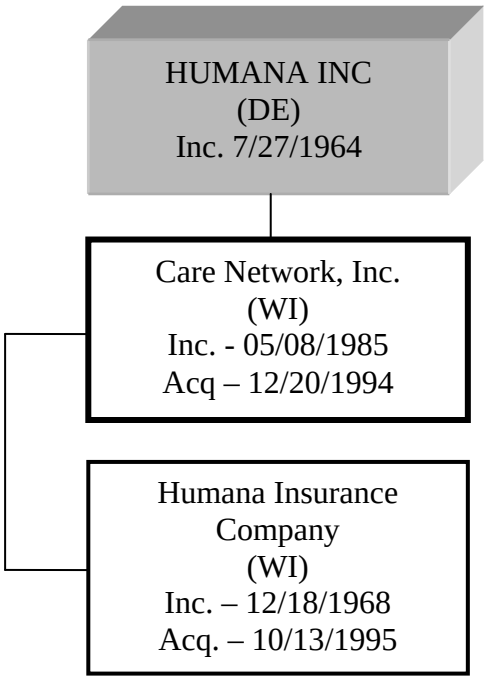
MARKET SHARE

Small Group	2007 MS	2007 WP	2008 MS	2008 WP	2009 MS	2009 WP
HHP	.03%	$379,563	.87%	$10,037,571	3.30%	$36,086,782
HIC	6.77%	$86,221,673	6.71%	$77,343,868	3.99%	$43,682,277

Individual	2007 MS	2007 WP	2008 MS	2008 WP	2009 MS	2009 WP
HHP						
HIC	3.21%	$31,368,000	4.02%	$41,920,000	4.35%	$47,455,000

STRUCTURE AS OF JUNE 30, 2009

An abbreviated organizational chart depicting HIC's relationship with its ultimate controlling entity and other affiliates, as of June 30, 2009 is depicted below:



PURPOSE AND SCOPE OF EXAMINATION

A state market conduct examiner with the Colorado Division of Insurance ("Division"), who was assisted by independent contract examiners reviewed certain business practices of HIC. The market conduct examination ("MCE") was performed in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205 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 examination was to determine HIC's compliance with Colorado insurance laws related to health insurance companies. Examination information contained in this report should serve only this purpose, except as provided by law pursuant to §§ 10-1-204 and 205, C.R.S. The conclusions and findings of this examination will become a 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 HIC. The MCE covered the period from July 1, 2007, through June 30, 2009.

The examination included review of the following:

Company Operations and Management
Advertising, Marketing and Sales
Complaints
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 HIC identifying any concerns and/or discrepancies. The comment forms contain a section that permits HIC 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 and small group health insurance laws. Examination findings may result in administrative action or other action by the Division, as set forth in the Colorado Revised Statutes (2010). Examiners may not have discovered all unacceptable or non-complying practices of HIC. Failure to identify specific practices of HIC 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 HIC's established policies, procedures, rules and/or guidelines.

METHODOLOGY

The examiners reviewed HIC's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to, but not limited 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 – coverage for students who take medical leave of absence.
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 health benefit plans – rules – benefit design advisory committee – repeal.
Section 10-16-106.3, C.R.S.	Uniform claims – billing codes – electronic claim forms.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
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.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – internal review – 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.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modification of health benefit plans.
Section 10-16-202, C.R.S.	Required provisions in individual sickness and accident policies.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
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 4-2-3	Advertisements of Accident and Sickness Insurance
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications of Pregnancy"

	For Use In Accident And Health Insurance Policies
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, Gynecologists And Certified Nurse Midwives 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 Issued 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 4-2-27	Procedures For Reasonable Modifications To Individual And Small Group Health Benefit Plans
Insurance Regulation 4-2-30	Concerning The Rules For Complying With Mandated Coverage Of Hearing Aids And Prosthetics
Insurance Regulation 4-6-5	Concerning Small Employer Group Health Benefit Plans And The 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

HIC's most recent market conduct examination by the Division prior to this examination was completed in 2003 and covered an exam period of January 1, 2002 through December 31, 2002.

Sampling Methodology

In accordance with the sampling methodology and sample sizes set forth in the 2010 NAIC Market Regulation Handbook ("Handbook"), the examiners reviewed the files that were randomly selected to constitute the sample base from a larger population of files.

Where the error rates of the samples indicated it would be appropriate to select an additional sample per the sampling instructions in the Handbook, but the initial results were conclusive, HIC was afforded the opportunity to agree that the initial sample was appropriate or request that an additional sample be selected. In each of these instances, HIC indicated that the initial sample was appropriate.

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 was determined to be systemic, or when the sampling process precluded establishment of 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.

Company Operations and Management

The examiners reviewed HIC 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 all small group business written during the period of the examination for compliance with the appropriate Colorado statutes and regulations.

Complaints

A review was performed on complaints received by HIC and the Division and traced into HIC's complaint records to verify accuracy in maintaining complaint records.

Marketing

The examiners reviewed various advertising and marketing material for compliance with Colorado insurance law.

Contract Forms

The examiners reviewed the following forms:

Four (4) most commonly sold small group plans

- HDHP
- Humana PPO 08
- Humana HDHP 08
- Covg First

Four Basic and Standard Plans

- Basic PPO Limited Mandate Plan
- Basic Indemnity Limited Mandate Plan
- Standard PPO Plan
- Standard Indemnity Plan

Eleven (11) most commonly sold individual policies

- Short Term Medical
- IMM-OV Copay
- AMP 250K, 75/55, 5K
- Monogram, IMM 100 Rx

- Monogram, IMM 100 Rx
  (SAB of $1,000)
- Autograph, HSAQ 100 Rx
  (Single Deductible of $2,500 and Lifetime Max of $5,000,000))
- Autograph, HSAQ 100
  (Single Deductible of $5,200 and Lifetime Max of $2,000,000)
- Autograph, HSAQ 100 Rx
  (Single Deductible of $5,000 and Lifetime Max of $5,000,000)
- Portrait IMM
  (RX Deductible of $500 and no SAB)
- Portrait IMM
  (No RX Deductible)
- Portrait IMM
  ($1,000 SAB)

Riders

- Maternity Rider
- Colorado Rider
- Term Life Rider

Applications (Individual Plans)

• HumanaOne Individual Insurance Application	CO-71000-A1	Rev. 12/2006
• HumanaOne Individual Insurance Application	CO-71000-A1	Rev. 2/2008
• HumanaOne Individual Insurance Application	CO-71002 2/2008	Rev. 7/2008
• HumanaOne Individual Insurance Application	CO-71002 2/2008	Rev. 7/2009

Applications (Group Plans)

• Humana Employee Enrollment Form	CO-72000 4/2008	
• CO Uniform Application	CO-72000 4/2008	
• Short-Term Medical Application	CO-71004 5/2008	Rev. 5/2008
• Short-Term Medical Application	CO-71004 5/2008	Rev. 5/2009

New Business Applications and Renewals

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

- 116 individual new business application files from a population of 13,954;
- Sixty (60) small group new business application files from a population of 60;
- 116 individual renewal files from a population of 20,664; and
- 115 small group renewal files from a population of 2,158.

Rating

The examiners reviewed the premium rates charged in the sample of new business individual files and the premium rates charged for both new and renewal small group sample files. 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 July 1, 2007 through June 30, 2009, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- 116 individual cancellation/non-renewal files from a population of 11,438;
- 114 small group cancellation/non-renewal files from a population of 1,201;
- 115 individual declined files from a population of 2,594; and
- The entire population of thirty-five (35) individual rescission files.

Claims

- 109 paid claims from a population of 800,376 claims paid during the examination period.
- 109 denied claims from a population of 107,051 denied during the examination period.

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

- 109 electronic claims from a population of 24,325 electronic claims received during the examination period.
- 109 non-electronic claims from a population of 9,745 non-electronic claims received during the examination period.
- 109 electronic and non-electronic claims from a population of 7,805 electronic and non-electronic claims received during the examination period.

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

Utilization Review

The examiners reviewed HIC's utilization review (UR) management program including policies and procedures. For the period of July 2, 2007 through June 30, 2009, the examiners reviewed the following for compliance with statutory requirements:

- 116 UR approval files from a population of 9,245;
- 114 UR declination files from a population of 1,566;
- 79 First Level UR appeal files from a population of 200;
- The entire population of five (5) Second Level UR appeal files;
- The entire population of seven (7) External Review UR appeals; and
- The entire population of three (3) Grievances.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of fifty-eight (58) findings in which HIC did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings.

Company Operations and Management: The examiners identified three (3) areas of concern in their review of HIC's Operations and Management.

Issue A1: Failure, in some instances, to maintain records required for market conduct purposes.

Issue A2: Certifying and Using Non-Compliant Forms. *(This was prior issue A1 in the findings of the 2002 final examination report.)*

Issue A3: Failure to maintain a document meeting the requirements and definition of an Access Plan.

Consumer Complaints: The examiners identified one (1) area of concern in their review of HIC's Complaint handling procedures.

Issue C1: Failure to maintain a complete record of all complaints received.

Contract Forms: The examiners identified thirty-eight (38) areas of concern in their review of HIC's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and any riders).

Issue E1: Failure to reflect coverage for early intervention services in individual and small group plans.

Issue E2: Failure to indicate mammograms and prostate screening are not covered in basic limited mandate health benefit plans.

Issue E3: Failure to correctly title the Basic Health Benefit Plans as "Limited Mandate" plans.

Issue E4: Failure to reflect correct annual maximum for durable medical equipment in the Basic PPO Limited Mandate Health Benefit Plan.

Issue E5: Failure to exempt child health supervision services from a deductible when services are provided by a non-network provider.

Issue E6: Failure to reflect that preauthorization is the sole responsibility of the participating provider.

Issue E7: Failure, for a period of time, to reflect correct out-of-pocket annual maximums in the Standard Indemnity Health Benefit Plan.

Issue E8: Failure to reflect a complete and correct description of when pre-existing condition exclusions apply.

Issue E9: Failure to reflect correctly the extent of coverage to be provided for home health services and hospice care.

Issue E10: Failure to reflect in the Basic and Standard Plans a correct definition of and the coverage to be provided for emergency care.

Issue E11: Failure to provide reimbursement for covered services when lawfully performed by a licensed provider that either resides in the insured's home or who is a family member. (*This was prior Issue E6 in the final 2002 examination report*).

Issue E12: Failure, in some instances, to reflect correct or complete outpatient coverage benefits to be provided for treatment of alcoholism.

Issue E13: Failure, in some instances, to reflect correct requirements for emergency admission notification.

Issue E14: Failure, in some instances, to reflect correct benefits for mammograms.

Issue E15: Failure, in some instances, to allow for other single and multi-organ transplants not specifically listed if they are determined to be medically necessary and meet clinical standards for the procedure.

Issue E16: Failure, in some instances, to reflect correct pre-existing condition limitations.

Issue E17: Failure to reflect correct "absence from work" termination of coverage provisions in Basic and Standard plans.

Issue E18: Failure, in some instances, to reflect the correct procedures for conducting utilization review.

Issue E19: Failure, in some instances, to allow coverage for hearing aids for dependent children under the age of eighteen (18) years.

Issue E20: Failure, in some instances, to reflect correct coverage provisions for emergency care to be provided.

Issue E21: Failure, in some instances, to provide coverage for treatment or benefits as a result of attempted suicide or intentionally self-inflicted injury whether sane or insane.

Issue E22: Failure, in some instances, to allow coverage to continue for an insured based solely on that individual's membership in the uniformed services of the United States.

Issue E23: Failure to reflect all required disclosures in short-term limited duration health insurance applications.

Issue E24: Failure, in some instances, to reflect complete or correct benefits to be provided for child health supervision services.

Issue E25: Failure, in some instances, to reflect complete or correct benefits to be provided for prostate cancer screening.

Issue E26: Failure, in some instances, to reflect the mandated coverage for cervical cancer vaccinations.

Issue E27: Failure, in some instances, to reflect the correct upper age limit for medically necessary therapy to be provided for congenital defects and birth abnormalities.

Issue E28: Failure, in some instances, to reflect that coverage is to be provided for replacement of prosthetic devices unless necessitated by misuse or loss.

Issue E29: Failure, in some instances, to reflect correct or complete grievance and appeal procedures.

Issue E30: Failure, in some instances, to clearly reflect the mandated coverage for complications of pregnancy and childbirth.

Issue E31: Failure to reflect correct coverage to be provided for newborns in a maternity rider.

Issue E32: Failure, in some instances, to reflect correct out-patient benefits for mental illness.

Issue E33: Failure to disclose counties of the state where there are no participating providers and to disclose in bold-faced type the disclosure concerning balance billing.

Issue E34: Failure, in some instances, to reflect the correct provisions under which coverage is to be provided for newborns.

Issue E35: Failure, in some instances, to reflect correctly or completely required provisions that are substantially the same, more favorable or at least as favorable to the insured persons and more favorable to the policyholder.

Issue E36: Failure, in some instances, to reflect that physical, occupational and speech therapy are a covered benefit without regard as to whether the purpose of the therapy is to maintain or to improve functional capacity.

Issue E37: Failure to reflect in a Colorado Rider that if prior authorization is obtained, inpatient hospitalization is to be covered for dental care procedures provided to dependent children who meet certain criteria.

Issue E38: Failure, in some instances, to reflect acceptable reasons for termination of coverage.

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

Issue F1: Failure to file or utilize rates filed with the Colorado Division of Insurance on individual policies as required by Colorado insurance law.

New Business Applications and Renewals: The examiners identified four (4) issues in their review of new business applications and renewals.

Issue G1: Failure, in some instances, to define correctly a significant break in coverage.

Issue G2: Failure to reflect all required information in application forms concerning replacement of coverage.

Issue G3: Failure, in some instances, of proper use of underwriting criteria for small groups.

Issue G4: Use of a group policy issued to the Employers Health Insurance Benefit Trust, a non-approved Trust, to offer conversion plans to eligible individuals.

Cancellations/Non-Renewals/Declinations/Rescissions: The examiners identified four (4) areas of concern identified during the review of the cancellations, non-renewals, declination, and rescission files.

Issue H1: 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 H2: Failure, in some instances, to reflect a definition of "significant break in coverage" on Certificates of Creditable Coverage.

Issue H3: Failure, in some instances, to return unearned premium to the insured but in no event more than forty-five days after the effective date of any notification of cancellation or termination or as otherwise established.

Issue H4: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan.

Claims: The examiners identified two (2) areas of concern in their review of the claims handling practices of HIC.

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

Issue J2: Failure, in some instances, to properly investigate, adopt, and implement reasonable standards for the prompt resolution of medical payment claims and hold covered persons harmless for nonparticipating provider fees, as required by Colorado insurance law.

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

Issue K1: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level review appeals.

Issue K2: Failure, in some instances, to provide notification of the first level utilization review decision within the time period required by Colorado insurance law.

Issue K3: Failure, in some instances, to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.

Issue K4: Failure to comply with the notification requirements pertaining to an External Review.

Issue K5: Failure, in some instances to include correct information regarding preauthorization in utilization review approval letters.

FACTUAL FINDINGS

HUMANA INSURANCE COMPANY

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure, in some instances, to maintain records required for market conduct purposes.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of § 10-1-109(1), C.R.S., states in part:

> . . .
>
> Section 4. Records Required For Market Conduct Purposes
>
> A. *Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations*, including but not limited to, company operations and management, policyholder services, claim's practices, rating, *underwriting*, marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two prior calendar years. [Emphasis added.]

Certificates of Creditable Coverage
July 1, 2007-June 30, 2009

Population	Sample	Incidence of Error	Percentage to Sample
5,394	116	116	100%

The examiners requested a sample of Certificates of Creditable Coverage for small groups that had cancelled during the period under examination. HIC is not in compliance with Colorado insurance law in that it could not produce the requested Certificates of Creditable Coverage for small groups, and therefore no verification of information contained in the Certificates could be performed. HIC could produce only the name of the insured and a run date of when the Certificate was produced, but no other information was available. Instead of the actual Certificate of Creditable Coverage provided for each individual in the sample, HIC provided a template with generic information.

Recommendation No 1:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 1-1-7, which was promulgated under the Commissioner's authority set forth at §10-1-109(1), C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has revised its processes and procedures to ensure that all future records required for market conduct purposes are retained and can be provided within the time-frames required by Colorado insurance law.

Issue A2: Certifying and Using Non-Compliant Forms. *(This was prior issue A1 in the findings of the 2002 final examination report.)*

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:
>
> . . .
>
> Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

An officer of HIC must certify compliance with Colorado insurance law with all initial filings of policy forms and on the annual report of policy forms. HIC is not in compliance with Colorado insurance law in that not all forms that were certified and used by HIC in 2008 and 2009 were in compliance with statutory requirements as evidenced by Issues #E1 through #E38.

Recommendation No. 2:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has corrected its procedures to ensure that all forms issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of HIC.

In the market conduct examination for the period January 1, 2002 through December 31, 2002, HIC was cited for certifying forms that did not comply with Colorado insurance law. The violation resulted in Recommendation #9 of Final Agency Order O-04-056 that HIC should ensure that written evidence of coverage forms issued or delivered to Colorado insureds comply with statutory mandates as certified by an officer of HIC. Failure to comply with the previous order of the Commissioner constitutes a willful violation of § 10-3-1104, C.R.S.

Issue A3: Failure to maintain a document meeting the requirements and definition of an Access Plan.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

> . . .
>
> (9) Beginning January 1, 1998, *a carrier shall maintain and make available upon request of the commissioner,* the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, *in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request.* In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan. *The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. . . .* [Emphases added.]

HIC is not in compliance with Colorado insurance law in that it could not provide any document meeting the requirements and definition of an Access Plan that is to be maintained for each managed care network that the carrier offers in the state.

Recommendation No. 3:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed a written access plan for each managed care network that the carrier offers in this state and implemented procedures to ensure that it maintains an Access Plan, which meets the definition required by Colorado insurance law, for each managed care network plan that the carrier offers in the state.

CONSUMER COMPLAINTS

Issue C1: Failure to maintain a complete record of all complaints received.

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:

. . .

(i) Failure to maintain complaint handling procedures: *Failing of any insurer to maintain a complete record of all the complaints which it has received since the date of its last examination*. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this paragraph (i), "complaint" shall mean any written communication primarily expressing a grievance. [Emphasis added.]

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, Colorado Revised Statutes (C.R.S.), states in part:

. . .

Section 10 First Level Review

. . .

C. Pursuant to Section 10-3-1104(1)(i), C.R.S., *all written requests for a first level review must be entered into the carrier's complaint record*. [Emphasis added.]

Section 11 Voluntary Second Level Review

. . .

C. *A complaint record entry shall be made for all voluntary second level reviews*, pursuant to Section 10-3-1104(1)(i), C.R.S., and Colorado Insurance Regulation 6-2-1. [Emphasis added.]

Colorado Insurance Regulation 6-2-1, Complaint Record Maintenance, promulgated under the authority of Section 10-3-1110, C.R.S., states in part:

. . .

V. Maintenance of Record

> The complaint record shall be kept on a calendar year basis and the number of complaints by line of insurance, function, reason, disposition, and state of origin shall be compiled not less frequently than annually.

In response to the request to provide a complaint register for the period under examination HIC indicated that only four (4) consumer complaints had been directly received during the period under examination. HIC provided a population of 200 Colorado Utilization Review First Level Appeal files. A sample of seventy-nine (79) files was chosen for review. HIC is not in compliance with Colorado insurance law as none of these seventy-nine (79) written requests for a first level review were recorded on the complaint log as required. Additionally, HIC provided a population of five (5) Utilization Review Second Level Appeal files for review and these requests were not recorded on the complaint log as required.

Recommendation No. 4:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. and Colorado Insurance Regulations 4-2-17 and 6-2-1, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has corrected its procedures to ensure that a complete record of all complaints is maintained by making a complaint record entry for all written requests for a first level review and for any requests for a voluntary second level review as required by Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure to reflect coverage for early intervention services in individual and small group plans.

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:

. . .

(II) "Early intervention services" means services as defined by the division in accordance with part C that are authorized through an eligible child's IFSP but that exclude nonemergency medical transportation; respite care; service coordination, as defined in 34 CFR 303.12 (d) (11); and assistive technology, unless assistive technology is covered under the applicable insurance policy or service or indemnity contract as durable medical equipment.

(III) "*Eligible child*" means an *infant or toddler, from birth through two years of age,* who is an eligible dependent and who, as defined by the department pursuant to section 27-10.5-702 (9), C.R.S., *has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to section 27-10.5-102 (11) (c), C.R.S.*

(IV) *"Individualized family service plan" or "IFSP*" means a written plan developed pursuant to 20 U.S.C. sec. 1436 and 34 CFR 303.340 that authorizes early intervention services to an eligible child and the child's family. An IFSP shall serve as the individualized plan, pursuant to section 27-10.5-102 (20) (c), C.R.S., for an eligible child from birth through two years of age.

. . .

(VI) "*Qualified early intervention service provider*" or "qualified provider" *means a person or agency,* as defined by the division in accordance with part C, *who provides early intervention services and is listed on the registry of early intervention service providers pursuant to section 27-10.5-708 (1) (a), C.R.S.*

(b) (I) *All* individual and *group sickness and accident insurance policies or contracts* issued or renewed by an entity subject to part 2 of this article *on or after January 1, 2008,* and all service or indemnity contracts issued or renewed 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.

(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, or by such additional amount to be equal to the increase by the general assembly to the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that increase is more than the consumer price index increase.

For a period of time during the scope of the examination, HIC's small group plans and seven (7) of its individual policies reviewed did not comply with Colorado insurance law in that the coverage to be provided for early intervention services was not reflected in the certificates or policies. Effective January 1, 2008, the mandated early intervention services were to be made available annually to an infant or toddler with significant delays in development or diagnosed with a physical or mental condition. The benefit is to be provided in accordance with Colorado insurance law from the child's birth up to the third birthday.

The provision for early intervention services was not implemented in the small group plans until June 27, 2008 and not until March 23, 2009 in seven (7) of the individual policies.

Form Name	Form Number	Marketed
HDHP Plan	CC2003-C	07/01/05 –Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03-Stopped Marketing 4/21/07
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM	CO-70129 SCH 8/2002	4/21/07 to current

($1,000 SAB)

Recommendation No. 5:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has revised all applicable forms (including copies of all revised forms) to reflect the mandatory coverage for early intervention services as required by Colorado insurance law.

Issue E2: Failure to indicate mammograms and prostate screening are not covered in basic limited mandate health benefit plans.

Colorado Insurance Regulation 4-6-5 (Effective January 1, 2008), 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:

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

Effective 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". [Emphases added.]

Attachment 1
Covered Preventive Services [1]

Age 19-39	Females ages 35-39: 1 baseline screening mammogram and clinical breast exam **(Mammogram is *not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.]
Age 40-64	Females ages 40-49: 1 screening mammogram and clinical breast exam every 2 years (annually, if high risk) **(Mammogram is *not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.] Females ages 50-64: 1 screening mammogram and clinical breast exam every 12 months **(Mammogram is not covered under the *Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.] Males: Prostate screening as specified in state law **(*Not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.]

Age 65 and older	Females age 65 to 74: 1 screening mammogram and clinical breast exam every 12 months **(Mammogram is not covered under the *Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.] Males: Prostate screening as specified in state law **(*Not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.]

1. Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

Emergency Insurance Regulation 08-E-12 9 (effective November 8, 2008, with benefits effective January 1, 2009), 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:

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

Effective January 1, 2009

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". [Emphases added.]

Attachment 1
Covered Preventive Services [1]

Age 19-39	Females ages 35-39: 1 baseline screening mammogram and clinical breast exam **(Mammogram is *not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.]
Age 40-64	Females ages 40-49: 1 screening mammogram and clinical breast exam every 2 years (annually, if high risk) **(Mammogram is *not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.] Females ages 50-64: 1 screening mammogram and clinical breast exam every 12 months **(Mammogram is not covered under the *Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.] Males: Prostate screening as specified in state law **(*Not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit**

	Plans.) [Emphasis added.]
Age 65 and older	Females age 65 to 74: 1 screening mammogram and clinical breast exam every 12 months **(Mammogram is not covered under the *Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.] Males: Prostate screening as specified in state law **(*Not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.]

1. Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

Colorado Insurance Regulation 4-6-5 (effective February 1, 2009), 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:

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

Effective February 1, 2009

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". [Emphases added.]

Attachment 1
Covered Preventive Services [1]

Age 19-39	Females ages 35-39: 1 baseline screening mammogram and clinical breast exam **(Mammogram is *not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.]
Age 40-64	Females ages 40-49: 1 screening mammogram and clinical breast exam every 2 years (annually, if high risk) **(Mammogram is *not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.] Females ages 50-64: 1 screening mammogram and clinical breast exam every 12 months **(Mammogram is not covered under the *Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.] Males: Prostate screening as specified in state law **(*Not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit**

	Plans.) [Emphasis added.]
Age 65 and older	Females age 65 to 74: 1 screening mammogram and clinical breast exam every 12 months **(Mammogram is not covered under the *Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.] Males: Prostate screening as specified in state law **(*Not covered under the Basic Limited Mandate Health Benefit Plans* and the Basic HSA Limited Mandate Health Benefit Plans.)** [Emphasis added.]

1. Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

HIC's Basic PPO Limited Mandate Health Benefit Plan and the Basic Indemnity Limited Mandate Health Benefit plan are not in compliance with Colorado insurance law in that benefits for mammograms and prostate screening are reflected as covered preventive services in the certificates of coverage. Benefits for mammograms and prostate screening are not intended to be covered under the Basic Limited Mandate Health Benefit Plans as outlined in Colorado Insurance Regulation 4-6-5. This is also in conflict with what is reflected in the plan certificate under "Limitations and Exclusions which excludes any form of mammography or prostate screening.

Page 22 of the Basic PPO Certificate

PREVENTIVE CARE

Page 23 of the Basic PPO Certificate

Ages 40-64

Females ages 40-49: 1 screening mammogram and clinical breast (sic) every two years; annually, if high risk
Females ages 50-64: 1 screening mammogram and clinical breast (sic) every year

Males over age 50 and over the age of 40 years that are in high risk categories: annual prostate screening. The screening must consist of a PSA blood test and a digital rectal exam.

Ages 65 and older

Females ages 65 to 74: 1 screening mammogram and clinical breast exam every year.

Males: annual prostate screening. The screening must consist of a PSA blood test and a digital rectal exam.

Pages 57 and 60 of the Basic PPO Certificate and
Pages 48 and 51 of the Basic Indemnity Certificate reflect:

MEDICAL BENEFITS – LIMITATIONS AND EXCLUSIONS

This Policy does NOT provide benefits for:

- Any form of mammography or prostate screening;

Pages 16 and 17 of the Basic Indemnity Certificate

Ages 19-39

Females ages 35-39: 1 baseline screening mammogram and clinical breast exam

Ages 40-64

Females ages 40-49: Females ages 40-49: 1 screening mammogram and clinical breast exam every two years, annually, if high risk

Males over age 50 and over age of 40 years that are in high risk categories: annual prostate screening. The screening must consist of a PSA blood test and a digital rectal exam.

Ages 65 and older

Females ages 65 to 74: 1 screening mammogram and clinical breast exam every year

Males: annual prostate screening. The screening must consist of a PSA blood test and a digital rectal exam.

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Health Benefit Plan	CO-57315-07 E BPC	6/1/09 to 10/31/09
CO Basic Indemnity Limited Mandate Health Benefit Plan	CO-57315-07 E BIC	6/1/08 to current

Recommendation No. 6:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed and implemented procedures to ensure that only correct benefits are reflected in its Basic Limited Mandate Health Benefit Plans as required by Colorado insurance law.

Issue E3: Failure to correctly title the Basic Health Benefit Plans as "Limited Mandate" plans.

Colorado Insurance Regulation 4-6-5 (effective January 1, 2008), 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 4 Rules

A. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three 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.]

. . .

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer *shall title* and market its basic health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider or HMO) (*Basic Limited Mandate Health Benefit Plan,* Basic HSA Health Benefit Plan or Basic HSA Limited Mandate Health Benefit Plan)] *for Colorado*". [Emphases added.]

Emergency Insurance Regulation 08-E-12 (effective November 8, 2008, with benefits effective January 1, 2009), 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 4 Rules

A. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three 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.]

. . .

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer *shall title* and market its basic health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider or HMO) (*Basic Limited Mandate Health Benefit Plan,* Basic HSA Health Benefit Plan or Basic HSA Limited Mandate Health Benefit Plan)] *for Colorado*". [Emphases added.]

Colorado Insurance Regulation 4-6-5 (effective February 1, 2009), 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 4 Rules

A. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three 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.]

. . .

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer *shall title* and market its basic health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider or HMO) (*Basic Limited Mandate Health Benefit Plan,* Basic HSA Health

> Benefit Plan or Basic HSA Limited Mandate Health Benefit Plan)] *for Colorado*". [Emphases added.]

HIC is not in compliance with Colorado insurance law in that the title of its Basic Health Benefit Plans is not complete. All the information required to identify the plans is displayed except the title of the plan design option.

Form Name	Form Number	Marketed
CO Basic PPO Health Plan (Basic PPO Limited Mandate Health Benefit Plan)	CO-57315-07 E BPC	6/1/09 to 10/31/09
Co Basic Indemnity Health Plan (Basic Indemnity Limited Mandate Health Benefit Plan)	CO-57315-07 E BIC	6/1/08 to current

Recommendation No. 7:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has properly identified each of its limited mandate plans with the correct plan design option as required by Colorado insurance law.

Issue E4: Failure to reflect correct annual maximum for durable medical equipment in the Basic PPO Limited Mandate Health Benefit Plan.

Colorado Insurance Regulation 4-6-5 (Effective January 1, 2008), 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:

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

Colorado Division of Insurance

Effective January 1, 2008

. . .

2. 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. *All basic and standard health benefit plans shall also comply with the following requirements*: [Emphasis added.]

   . . .

   B. **Benefit Modifications:** The *form and level of coverages* specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" *may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only*. [Emphases added.]

Benefit Grid

JANUARY 1, 2008 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC PPO PLAN	
22. DURABLE MEDICAL EQUIPMENT [17]	IN-NETWORK 70% Coinsurance	OUT-0F-NETWORK [1a] 50% Coinsurance
	$1,000 /year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)	

17: Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of all prosthetic devices applies to the annual DME maximum, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the annual maximum; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

Emergency Regulation 08-E-12 (Effective November 4, 2008), 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:

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

Colorado Division of Insurance

Effective January 1, 2009

. . .

2. 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. *All basic and standard health benefit plans shall also comply with the following requirements*: [Emphasis added.]

. . .

B. **Benefit Modifications:** The *form and level of coverages* specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" *may be*

expanded to add additional coverage through a rider or endorsement at the option of the policyholder only. [Emphases added.]

Benefit Grid

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC PPO PLAN	
22. DURABLE MEDICAL EQUIPMENT [17]	IN-NETWORK 70% Coinsurance	OUT-0F-NETWORK [1a] 50% Coinsurance
	$1,000 /year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)	

17: Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of all prosthetic devices applies to the annual DME maximum, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the annual maximum; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

Colorado Insurance Regulation 4-6-5 (Effective February 1, 2009), 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:

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

Colorado Division of Insurance

Effective February 1, 2009

. . .

2. 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. *All basic and standard health benefit plans shall also comply with the following requirements*: [Emphasis added.]

. . .

B. **Benefit Modifications:** The *form and level of coverages* specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" *may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only*. [Emphases added.]

Benefit Grid

FEBRUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC PPO PLAN	
22. DURABLE MEDICAL EQUIPMENT [17]	IN-NETWORK 70% Coinsurance	OUT-0F-NETWORK [1a] 50% Coinsurance
	$1,000 /year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)	

17: Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of all prosthetic devices applies to the annual DME maximum, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the annual maximum; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

HIC is not in compliance with Colorado insurance law in that the $2,000 annual combined maximum benefit allowed for durable medical equipment is more liberal than allowed by Colorado insurance law. The Basic and Standard plans are to reflect the benefits as outlined in Colorado Insurance Regulation 4-6-5 and any additional benefits are to be offered by a rider or endorsement at the option of the policyholder only.

Page 21 of the Basic Limited Mandate PPO Plan reflects the following:

SCHEDULE AND DESCRIPTION OF MEDICAL BENEFITS
(Continued)

Durable Medical Equipment

Covered Expense for Services received from Preferred and Non-Preferred providers are limited to a combined maximum $2,000 per calendar year for each Covered person payable at: …

Form Name	Form Number	Marketed
CO Basic Limited Mandate PPO Health Plan	CO-57315-07 E BPC	6/1/2008-10/31/09

Recommendation No. 8:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to show provide such documentation, it shall provide written evidence to the Division that it has developed and revised all applicable forms to reflect correct benefits for durable medical equipment as required by Colorado insurance law.

Issue E5: Failure to exempt child health supervision services from a deductible when services are provided by a non-network provider.

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.* …

(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.

(c) *Benefits for child health supervision services shall be exempt from a deductible or dollar limit provision in any individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident and such exemption shall be explicitly stated in such a plan.* … [Emphasis added.]

Colorado Insurance Regulation 4-6-5 (effective January 1, 2008), 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:

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

Colorado Division of Insurance
Effective 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". [Emphasis added.]

. . .

Benefit Grid

January 1, 2008 Colorado Basic Limited Mandate Health Benefit Plans:

Indemnity, PPO, and HMO

Part B: SUMMARY OF BENEFITS

	BASIC PPO PLAN	
Basic Limited Mandate Health Benefit Plan	In-Network	Out-Of-Network [1a]
9. **Preventive Care** [6]	For all plans, only specified preventive services are covered	
a) Children's Services *(No deductible prior to application of coinsurance.)* [Emphasis added.]	$40 copay/visit $40 copay/visit	50% coinsurance
b) Adults' services[6a]		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.

6a Prostate cancer screening and routine mammograms are not covered.

Emergency Regulation 08-E-12 (effective November 4, 2008 with benefits effective January 1, 2009), 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:

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

Colorado Division of Insurance
Effective January 1, 2009

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". [Emphasis added.]

. . .

Benefit Grid

January 1, 2009 Colorado Basic Limited Mandate Health Benefit Plans:
Indemnity, PPO, and HMO

Part B: SUMMARY OF BENEFITS

	BASIC PPO PLAN	
Basic Limited Mandate Health Benefit Plan	In-Network	Out-Of-Network [1a]
9. **Preventive Care** [6]	For all plans, only specified preventive services are covered	
c) Children's Services *(No deductible prior to application of coinsurance.)* [Emphasis added.]	$40 copay/visit $40 copay/visit	50% coinsurance
d) Adults' services[6a]		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.

6a Prostate cancer screening and routine mammograms are not covered.

Colorado Insurance Regulation 4-6-5 (effective February 1, 2009), 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:

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

Colorado Division of Insurance
Effective February, 2009

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". [Emphasis added.]

. . .

Benefit Grid

February 1, 2009 Colorado Basic Limited Mandate Health Benefit Plans:

Indemnity, PPO, and HMO

Part B: SUMMARY OF BENEFITS

	BASIC PPO PLAN	
Basic Limited Mandate Health Benefit Plan	In-Network	Out-Of-Network [1a]
9. **Preventive Care** [6]	For all plans, only specified preventive services are covered	
e) Children's Services *(No deductible prior to application of coinsurance.)* [Emphasis added.]	$40 copay/visit $40 copay/visit	50% coinsurance
f) Adults' services[6a]		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.

6a Prostate cancer screening and routine mammograms are not covered.

HIC's Basic PPO Limited Mandate Health Benefit Plan is not in compliance with Colorado insurance law as it indicates that a deductible is to be applied prior to application of the coinsurance for preventive care for covered persons ages 13 and older if services are provided by a non-preferred provider. The Summary of Benefits displayed in the benefit grids in Colorado Insurance Regulation 4-6-5 applicable to HIC's plans do not reflect a cut-off age of 12 for this requirement of no deductible applying prior to application of the coinsurance for children's preventive care.

HIC's HDHP Small Group Plan is not in compliance with Colorado insurance law as it indicates that a deductible is to be applied prior to application of the coinsurance for preventive screenings for covered persons through age twelve (12) if services are provided by a non-preferred provider.

Page 22 of HIC's Basic PPO Limited Mandate Plan reflects the following:
PREVENTIVE CARE

Covered expenses for preventive care **Services** will be payable at:

- Non-Preferred Provider

  _ 50% not subject to **Deductible** for **Covered Persons** ages 12 and younger; or
  _ 50% in excess of the **Deductible** for **Covered Persons** ages 13 and older.

Page 15 of the HDHP Small Group Plan reflects the following:

SCHEDULE OF BENEFITS

Preventive screenings for covered persons through age 12

Includes preventive radiology. Excludes preventive laboratory.

Non-network health care practitioner	70% benefit payable after *non-network*

	provider deductible

Page 16 of the HDHP Small Group Plan reflects the following:

SCHEDULE OF BENEFITS

Preventive screenings and immunizations for covered persons 13 years of age to age 18

Includes preventive laboratory and radiology.

Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Health Benefit Plan	CO-57315-07 E BPC	6/1/09 to 10/31/09
HDHP Small Group Plan	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07

Recommendation No. 9:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect that a deductible is not to be applied prior to application of the coinsurance if preventive care services for children are provided by a non-preferred provider as required by Colorado insurance law.

Issue E6: Failure to reflect that preauthorization is the sole responsibility of the participating provider.

Section 10-16-705, C.R.S., Requirements for carriers 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 HIC's Basic and Standard plans, small group health benefit plans and its individual policies reviewed are not in compliance with Colorado insurance law in that they reflect that the covered person is responsible for informing the health care practitioner of the preauthorization requirements and that the covered person or the health care practitioner must contact HIC to obtain the appropriate authorization. Colorado insurance law requires that every contract between a carrier and a provider must contain 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.

In addition, all health benefit plans reviewed reflect that if preauthorization is not obtained, the benefit payable for any covered expenses will be reduced by $500 or 50% of covered expenses after any applicable deductible or copayment. The individual policies, under "Impact on benefit payment", clearly reflect that if preauthorization is not obtained, the *covered person* is required to pay $500 of covered expenses before HIC will consider payment of submitted charges. The $500 reduction, which is not applied toward the *deductible* or *coinsurance out-of-pocket limit*, imposes a penalty on the covered person when it is not their responsibility to obtain the preauthorization.

Page 50 of the Basic PPO Limited Mandated Health Benefit Plan reflects:

UTILIZATION MANAGEMENT

PRESERVICE NOTIFICATION PROCEDURES:

WHAT YOU ARE REQUIRED TO DO:

If You are to receive any of the Services listed above, **You** or **Your Qualified Practitioner** must contact Us by telephone or in writing:

Page 52 of the Basic PPO Limited Mandate Health Benefit Plan reflects:

FAILURE TO MEET PRESERVICE NOTIFICATION/PREAUTHORIZATION REQUIREMENTS

Preservice Notification is required prior to a **Confinement,** non-emergency Outpatient **Surgery**, or within 48 hours of an emergency admission. If **Preservice Notification** is not provided, benefits will NOT be payable for the first $500 of **Covered Expense**.

The $500 penalty is NOT applied to the Deductible or Out-of-Pocket Limit shown on the Schedule of Benefits.

Page 82 of the Basic PPO Limited Mandate Benefit Plan titled "Amendment" reflects:

PREAUTHORIZATION REQUIREMENTS AND PENALTY

. . .

The ***Covered Person*** *is responsible* for informing the **Qualified Practitioner** of the preauthorization requirements. The **Covered Person** or the **Qualified Practitioner** must contact **Us** by telephone, electronic mail**,** via **Our** Website or in writing to request the appropriate authorization.

. . .

If any required **preauthorization** of **services** or supplies is not obtained, the benefit payable for any covered expenses incurred for the services, will be reduced by 50%, after any applicable **Deductibles** or Co-payments. If the rendered **services** are <u>not</u> covered expenses, no benefits are payable. The out-of-pocket amounts incurred by the Covered Person due to these benefit reductions may <u>not</u> be used to satisfy any out-of-pocket limits. This **preauthorization** penalty will apply if the **Covered Person** received the **services** from either a preferred provider or a Non-preferred provider when authorization is required and <u>not</u> obtained.

Page 5 of the Basic Indemnity Health Benefit Plan,
Page 6 of the Standard Indemnity Health Benefit Plan, and
Page 12 of the Standard PPO Health Benefit Plan reflect:

SCHEDULE AND DESCRIPTION OF MEDICAL BENEFITS

PRESERVICE NOTIFICATION/PREAUTHORIZATION REQUIREMENTS

You or **Your Qualified Practitioner** must contact **Us** by telephone or in writing:

. . .

Preservice Notification is required prior to **Confinement**, non-emergency Outpatient **Surgery** or within 48 hours of an emergency admission or by the end of the first business day following the emergency, whichever is later. If **Preservice Notification** is not received, benefits will NOT be payable for the first $500 of **Covered Expense.**

The $500 penalty is NOT applied to the Deductible of Out-of-Pocket Limit.

Page 43 of the Basic Indemnity Health Benefit Plan,
Page 44 of the Standard Indemnity Health Benefit Plan, and
Page 53 of the Standard PPO Health Benefit Plan reflect:

UTILIZATION MANAGEMENT

FAILURE TO MEET PRESERVICE NOTIFICATION/PREAUTHORIZATION REQUIREMENTS

Preservice Notification is required prior to **Confinement**, non-emergency Outpatient **Surgery** or within 48 hours of an emergency admission. If **Preservice Notification** is not provided, benefits will NOT be payable for the first $500 of **Covered Expense**.

The $500 penalty is NOT applied to the **Deductible** or **Out-of-Pocket Limit** shown on the Schedule of Benefits.

Pages 8 and 12 of HIC's four (4) small group plans reviewed reflect:

UNDERSTANDING YOUR COVERAGE

Preauthorization

. . .

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements. *You* or *your health care practitioner* must contact *us* by telephone, *electronic mail*, or in writing to obtain the appropriate authorization. *Your* identification card will show the *health care practitioner* the telephone number to call to request the appropriate authorization. Benefits are not paid at all for services or supplies that are not *covered expenses.*

SCHEDULE OF BENEFITS

Preauthorization requirements and penalty

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements. *You* or *your health care practitioner* must contact *us* by telephone, electronic mail, or in writing to request the appropriate authorization. Benefits are not paid at all for services or supplies that are not *covered expenses.*

If any required *preauthorization* of services or supplies is not obtained, the benefit payable for any *covered expenses* incurred for the services, will be reduced by 50%, after any applicable *deductibles* or *copayments*. If the rendered services are not *covered expenses*, no benefits are payable. The out-of-pocket amounts incurred by *you* due to these benefit reductions may not be used to satisfy any *out-of-pocket limits.* This *preauthorization* penalty will apply if *you* received the services from either a *network provider* or a *non-network provider* when *preauthorization* is required and not obtained.

Pages 13, 14 & 52 of the Short Term Medical-STM 100/75 Policy,
Pages 16, 17 & 68 of the IMM-OV Copay Policy,
Pages 16, 17 & 64 of the AMP 250K, 75/55, 5K Policy,
Pages 16, 17 & 68 of the Monogram, IMM 100Rx Policy,
(No Supplemental Accident Benefit)
Pages 16, 17 & 86 of the Monogram, IMM 100Rx Policy,
(SAB of $1,000)
Pages 16, 17 & 68 of the Autograph, HSAQ 100 Rx Policy,
(Single Deductible of $2,500 and Lifetime Max of $5,000,000)
Pages 15, 16 & 63 of the Autograph, HSAQ 100 Rx Policy,
(Single Deductible of $5,000 and Lifetime Max of $5,000,000)
Pages 15, 16 & 83 of the Autograph, HSAQ 100 Rx Policy,
(Single Deductible of $5,000 and Lifetime Max of $5,000,000)
Pages 16, 17 & 68 of the Portrait IMM Policy,
(RX deductible of $500 and no SAB)
Pages 16, 17 & 68 of the Portrait IMM Policy
(No RX deductible), and
Pages 16, 17 & 68 of a Portrait Policy (RX deductible of $500 and no SAB),
reflect:

UTILIZATION MANAGEMENT

Preauthorization

A *covered person* or the *covered person's healthcare practitioner* is required to notify *us* and obtain *our* approval through the *preauthorization* process for certain *services* specified below.

Preservice notice

A *covered person* is required to notify *us* prior to receiving certain *services*. …

Impact on benefit payment

If *we* do not receive the required pre service notification, the *covered person* will be required to pay $500 of *covered expense* before *we* begin to pay *covered expenses*. Further, the $500 *expense incurred* by the *covered person* for the *service* will not be applied toward the *deductible* or *coinsurance out-of-pocket limit*.

If *preauthorization* is not received from *us*, no benefits will be payable for these *services*.

One of the two (2) following section headings was used for all the policies:

POLICY DEFINITIONS

MEDICAL GLOSSARY

Preservice notification means notification to *us* by *you*, the *covered person* or the *covered person's healthcare practitioner*.

Form Name	Form Number	Marketed
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
CO Basic PPO Limited Mandate	CO-57315-07 E BPC	06/01/09 - 10/31/09
CO Basic Indemnity Plan	CO-57315-07BIN 3/2008	06/01/08 to current
CO Standard Indemnity Plan	CO-57315-07 E SIC	06/01/06 to current
CO Standard PPO Plan	CO-57315-07 E SPC	06/01/08 to current
Short Term Medical-STM 100/75	GN-71008-01 1/2008	3/6/09 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000))	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 10:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-705, C.R.S. In the event HIC is unable to show provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect that preauthorization for services is the sole responsibility of the provider and that any penalty is not placed on the covered person as required by Colorado insurance law.

Issue E7: Failure, for a period of time, to reflect correct out-of-pocket annual maximums in the Standard Indemnity Health Benefit Plan.

Colorado Insurance Regulation 4-6-5 (effective January 1, 2008), 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:

. . .

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

Colorado Division of Insurance

Effective January 1, 2008

. . .

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*". [Emphasis added.]

. . .

5. All basic and standard health benefit plans shall also comply with the following requirements:

. . .

B. Benefit Modifications: The form and level of coverages specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" may be expanded to add additional coverage *through a rider or endorsement at the option of the policyholder only*. [Emphasis added.]

. . .

Benefit Grid

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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD INDEMNITY PLAN
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	$4,000
b) Family	$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. 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.

Emergency Insurance Regulation 4-6-5 (effective November 4, 2008 with benefits effective January 1, 2009), 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:

. . .

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

Colorado Division of Insurance

Effective January 1, 2009

. . .

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*". [Emphasis added.]

. . .

5. All basic and standard health benefit plans shall also comply with the following requirements:

. . .

B. Benefit Modifications: The form and level of coverages specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" may be expanded to add additional coverage

through a rider or endorsement at the option of the policyholder only. [Emphasis added.]

. . .

Benefit Grid

JANUARY 1, 2009 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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD INDEMNITY PLAN
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	$4,000
b) Family	$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. 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.

Colorado Insurance Regulation 4-6-5 (effective February 1, 2009), 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:

. . .

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

Colorado Division of Insurance

Effective February 1, 2009

. . .

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". [Emphasis added.]

. . .

5. All basic and standard health benefit plans shall also comply with the following requirements:

. . .

B. Benefit Modifications: The form and level of coverages specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" may be expanded to add additional coverage *through a rider or endorsement at the option of the policyholder only*. [Emphasis added.]

. . .

Benefit Grid

FEBRUARY 1, 2009 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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD INDEMNITY PLAN
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	$4,000
b) Family	$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. 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.

From January 1, 2008 through June 1, 2008, HIC's Standard Indemnity Health Benefit Plan was not in compliance with Colorado insurance law as the Out-Of-Pocket Annual Maximum amounts reflected were

incorrect. The Summary of Benefits, displayed for the above mentioned period of time, reflected the following Out-of-Pocket Annual Maximum amounts:

- Standard Indemnity Individual and Family $2,500 and $7,500 respectively

Pages 5 & 6 of the Standard Indemnity Health Benefit Plan reflect:

PAYMENT CONDITIONS

If a Covered Person is sick or injured, We will pay the charges for any treatment or Service that is listed in this section, but the benefits payable for all listed treatment or Service received during a calendar year will not be more than:

1. 80% of each person's **Covered Expense**, in excess of the **Deductible** amount described in this section until **Out-Of-Pocket Expenses** are:
   A. $2,500 per **Covered Person**; or
   B. $7,500 for all persons in the same family (an **Employee** and Covered **Dependents**); and

2. 100% of **Covered Expenses** in excess of:
   A. $2,500 of **Out-Of-Pocket Expenses** per **Covered Person**; or
   B. $7,500 of **Out-of-Pocket Expenses** for all persons in the same family (an **Employee** and Covered **Dependents**).

Form Name	Form Number	Marketed
CO Standard Indemnity Plan	CO-57315-07 E SIC	06/01/06 through current

Recommendation No. 11:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to show such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect correct out-of-pocket annual maximum amounts as required by Colorado insurance law.

Issue E8: Failure to reflect a complete and correct description of when pre-existing condition exclusions apply.

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*. [Emphases added.]

Colorado Insurance Regulation 4-6-5 (effective January 1, 2008), 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:

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

Colorado Division of Insurance

Effective 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". [Emphasis added.]

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*". [Emphases added.]

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

   All other provisions of Title 10 which apply to group sickness and accident insurers, nonprofit health and hospital service corporations, and health maintenance organizations, and all rules and regulations related to those provisions, as they relate to small employer group plans, shall also apply.

Benefit Grid

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 the 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	BASIC PPO PLAN	
		IN-NETWORK	OUT-OF NETWORK
34. How Does The Policy Define A "Pre-Existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date of enrollment *or, if earlier, the first day of the waiting period*; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy. [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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN	
		IN-NETWORK	OUT-OF NETWORK
34. How Does The Policy Define A "Pre-Existing	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date		

Condition"?	of enrollment *or, if earlier, the first day of the waiting period*; except that pre-existing condition exclusions may not be imposed on a newly adopted child, child placed for adoption, a newborn, other special enrollees, or for pregnancy. [Emphasis added.]

Emergency Insurance Regulation 4-6-5 (effective November 4, 2008 with benefits effective January 1, 2009), 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:

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

Colorado Division of Insurance

Effective January 1, 2009

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". [Emphasis added.]

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*". [Emphases added.]

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

   All other provisions of Title 10 which apply to group sickness and accident insurers, nonprofit health and hospital service corporations, and health maintenance organizations, and all rules and regulations related to those provisions, as they relate to small employer group plans, shall also apply.

Benefit Grid

January 1, 2009 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 the 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	BASIC PPO PLAN	
		IN-NETWORK	OUT-OF NETWORK
34. How Does The Policy Define A "Pre-Existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date of enrollment *or, if earlier, the first day of the waiting period*; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy. [Emphasis added.]		

January 1, 2009 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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN	
		IN-NETWORK	OUT-OF NETWORK
34. How Does The Policy Define A "Pre-Existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date of enrollment *or, if earlier, the first day of the waiting period*; except that pre-existing condition exclusions may not be imposed on a newly adopted child, child placed for adoption, a newborn, other special enrollees, or for pregnancy. [Emphasis added.]		

Colorado Insurance Regulation 4-6-5 (effective February 1, 2009), 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:

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

Colorado Division of Insurance

Effective February 1, 2009

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". [Emphasis added.]

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*". [Emphases added.]

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

   All other provisions of Title 10 which apply to group sickness and accident insurers, nonprofit health and hospital service corporations, and health maintenance organizations, and all rules and regulations related to those provisions, as they relate to small employer group plans, shall also apply.

Benefit Grid

February 1, 2009 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 the 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	BASIC PPO PLAN	
		IN-NETWORK	OUT-OF NETWORK
34. How Does The Policy Define A "Pre-Existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date of enrollment *or, if earlier, the first day of the waiting period*; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy. [Emphasis added.]		

February 1, 2009 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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN	
		IN-NETWORK	OUT-OF NETWORK
34. How Does The Policy Define A "Pre-Existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date of enrollment *or, if earlier, the first day of the waiting period*; except that pre-existing condition exclusions may not be imposed on a newly adopted child, child placed for adoption, a newborn, other special enrollees, or for pregnancy. [Emphasis added.]		

HIC's small group and Basic and Standard Health Benefit plans reviewed are not in compliance with Colorado insurance law. The Schedule of Benefits addressing when a Pre-Existing Condition exclusion will not apply is incomplete in the following way:

(1) It does not reflect that a pre-existing condition exclusion may not be applied to an adopted child, or a child placed for adoption who has not attained eighteen years of age.

Page 25 of Basic PPO Limited Mandate Health Benefit Plan,
Page 18 of the Basic Limited Indemnity Health Benefit Plan,
Page 19 of the Standard Indemnity Health Benefit Plan, and
Page 26 of the Standard PPO Health Benefit Plan reflect:

SCHEDULE OF BENEFITS

PRE-EXISTING CONDITION LIMITATION

The **Pre-Existing Condition** exclusion will NOT apply to:

- A newborn child who is covered on his/her date of birth; or
- A legally adopted child, including a child placed with the **Employee** for the purpose of adoption, if coverage is effective on the child's eligibility date.

The Glossary for the small group plans reflects an incomplete Pre-Existing Condition in the following way:

(1) That if the first day of the "waiting period" is earlier than the six (6) months preceding enrollment, the period of time for calculating a preexisting condition exclusion or limitation will run from the first day of the "waiting period".

Page 117 of the HDHP small group plan,
Page 116 of the Humana HDHP 08 small group plan,
Page 118 of the Humana PPO 08 small group plan and
Page 118 of the Humana Coverage First 08 small group plan reflect:

Pre-existing condition means a *sickness or bodily injury* for which *you* have received medical attention during the six months prior to *your enrollment date*. For

the purposes of this definition, medical attention means care, advice, examination, treatment, services, medication, procedures, tests, consultation, referral or diagnosis.

The Definition for the Basic and Standard plans reflects an incomplete Pre-Existing Condition in the following way:

(1) That if the first day of the "waiting period" is earlier than the six (6) months preceding enrollment, the period of time for calculating a preexisting condition exclusion or limitation will run from the first day of the "waiting period".

Page 35 of the Basic PPO Limited Mandate Plan,
Page 28 of the Basic Indemnity Limited Mandate Plan,
Page 36 of the Standard PPO Plan, and
Page 29 of the Standard Indemnity Plan reflect:

> **Pre-Existing Condition** means a physical or mental condition for which **You** have received medical attention (medical attention means care, advice, examination, treatment, services, medication, procedures, tests, consultation, referral or diagnosis) during the 6 months prior to **Your Enrollment Date**.

Form Name	Form Number	Marketed
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
Basic PPO Limited Mandate	CO-57315-07 E BPC	06/01/09 - 10/31/09
Basic Limited Mandate Indemnity	CO-57315-07BIN 3/2008	06/01/08 to current
Standard Indemnity Plan	CO-57315-07 E SIC	06/01/06 to current
Standard PPO Plan	CO-57315-07 E SPC	06/01/08 to current

Recommendation No. 12:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S. and Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect a complete and correct description of when pre-existing condition exclusions apply as required by Colorado insurance law.

Issue E9: Failure to reflect correctly the extent of coverage to be provided for home health services and hospice care.

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

. . .

(8) Availability of hospice care coverage.

(a) As used in this subsection (8), unless the context otherwise requires:

(I) "Home health services" means home health services as defined in section 25.5-4-103(7), C.R.S., which are provided by a home health agency certified by the department of public health and environment.

(II) "Hospice care" means hospice services provided to a terminally ill individual by a hospice care program, licensed and regulated by the department of public health and environment pursuant to sections 25-1.5-103(1)(a)(I) and 25-3-101, C.R.S., or by others under arrangements made by such hospice care program.

(b) Notwithstanding any other provision of the law to the contrary, no individual or group policy of sickness and accident insurance issued by an entity 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 will be sold in this state unless a policyholder under such policy or plan is offered the opportunity to purchase coverage for benefits for the cost 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. [Emphasis 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 4 Requirements for Home Health Services

A. Definitions

. . .

(3) "Home health visit" is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to *4 hours by a home health aide shall* be considered as one visit. [Emphasis added.]

(4) "*Medical social services*" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or *counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.* [Emphases added.]

B. General Policy Provisions Pertaining to Home Health Care.

(1) The policy offering *shall provide that* home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization. *Prior hospitalization shall not be required.* [Emphases added.]

Section 5 Requirements for Hospice Care

A. Definitions.

. . .

(4) A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, *the primary care giver and individuals with significant personal ties.* [Emphasis added.]

. . .

(6) The "interdisciplinary team" is a group of qualified individuals, which *shall include, but is not limited to, a physician, registered nurse, clergy/counselors*, volunteer director, and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of hospice patient/families. [Emphasis added.]

(7) "Core services" are physician services, nursing services, pastoral counseling, trained volunteers, and social/counseling services routinely provided by hospice staff or volunteers.

(8) "*Social/counseling services*" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology *or counseling or the documented equivalent in a combination of education, training and experience*. [Emphases added.]

…

(12) Home care services" are hospice services, which are provided in the place the *patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer* facility. [Emphases added.]

…

(15) "Hospice levels of care."

…

(c) "Inpatient hospice respite care:" The level of care received when the patient is in a licensed facility *to provide the caregiver a period of relief. Inpatient respite care* may be provided only on an intermittent, non routine, short-term basis. It may be limited to periods of five days or less. [Emphasis added]

(16) "Bereavement" is that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered during the bereavement period.

. . .

(18) A "*benefit period"* for hospice care services *is a period of three months*, during which services are provided on a regular basis. [Emphases added.]

. . .

(20) An "*unrelated illness"* is a diagnosed condition, *which is not* a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness. [Emphasis added]

B. General Provisions Pertaining to Hospice Care.

. . .

(2) The policy offering shall provide that *benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period*. After the *exhaustion of three benefit periods,*

the insurer's *case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.* [Emphasis added]

. . .

(5) The policy offering *shall clearly indicate* that services and charges incurred *in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable* to all other illnesses and/or injuries. [Emphasis added]

C. Benefits for Hospice Care Services.

. . .

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team*: [Emphasis added.]

(a) Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;

(b) Intermittent and 24 hour on-call social/counseling services: and;

(c) Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days. [Emphasis added.]

(3) The policy offering shall include the following benefits, subject to the Policy's deductible, coinsurance and stoploss provisions, which are exclusive of and *shall not be included in the dollar limitation for hospice care benefits as specified in (2) above*. [Emphasis added.]

. . .

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and *shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above*). [Emphasis added]

HIC's HDHP certificate does not express correctly the extent of coverage to be provided for home health services in the following way:

HOME HEALTH SERVICES

Incorrect

- A limitation for Home Health Care Services is reflected that appears to be more limited than allowed by Colorado insurance law. Services up to four (4) hours by a home health aide shall be considered as one visit, the certificate incorrectly reflects two (2) hours or less as one visit.

HIC's Small Group and Basic and Standard Plans reviewed do not express completely the extent of coverage to be provided for home health services in the following ways:

HOME HEALTH SERVICES

Incomplete

- ***None of the plans*** reviewed reflect the provision that prior hospitalization is not required;

- ***The Basic and Standard Plans*** do not indicate that services up to four (4) hours by a home health aide shall be considered as one visit;

- ***None of the plans*** reflect the provision that "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

- Additionally, the **Small Group certificates** define "Home health care plan" as a plan of care and treatment to be provided in the home.

HOSPICE CARE

Incomplete

- The ***Small Group and Basic and Standard plans*** reviewed do not indicate that a "benefit period" for hospice care services is a period of three (3) months, during which services are provided on a regular basis;

- The ***Small Group and Basic and Standard plans*** reviewed do not indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries;

  - There is no provision in the ***Small Group*** certificates reviewed for hospice care benefits, which includes the "primary care giver and individuals with significant personal ties" in addition to those within the immediate family.

- The ***Basic and Standard Plans*** reviewed do not clearly reflect that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional period. Additionally, after the exhaustion of three (3) benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's medical director to determine the appropriateness of continuing hospice care;

- The ***Small Group*** certificates reflect that benefits will be paid for covered expenses incurred by a patient certified as terminally ill with a life expectancy of 18 months or less. There is no mention of the provision that at the exhaustion of the specified time period the insurer's case management staff will work with the patient's attending physician and the hospice director to determine the appropriateness of continuing hospice care;

- The ***Basic & Standard*** plans do not reflect that the total benefit for each benefit period for the three (3) routine home care services shall not be less than the per diem ($100) benefit multiplied by ninety-one (91) days;

- Nothing is reflected in the ***Basic & Standard*** plans reviewed to indicate that the twelve (12) benefits (except bereavement support services) are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits;

- Nothing is reflected in the ***Small Group or Basic and Standard plans*** reviewed concerning the "inpatient hospice respite care," one of the hospice levels of care that is to be covered when provided on an intermittent, non-routine, short-term basis and that may be limited to periods of five days or less.

Page 45 of the HDHP plan,
Page 46 of the Humana HDHP 08 plan,
Page 44 of the Humana PPO 08 plan, and
Page 46 of the Humana Coverage First 08 plan reflect:

> COVERED EXPENSES
>
> Home health care
>
> The "Schedule of Benefits" shows the maximum number of visits allowed by a representative of a *home health care agency*, if any. A visit by any representative of a *home health care agency* of ***two hours or less*** **will be counted as one visit**. [Emphasis added.]

Page 110 of the HDHP plan,
Page 109 of the Humana HDHP 08 plan,
Page 111 of the Humana PPO 08 plan, and
Page 111 of the Humana Coverage First 08 plan reflect:

> GLOSSARY
>
> ***Home health care plan*** means a plan of care and treatment for *you* to be provided *in your home*. [Emphasis added.]

Page 109 of the HDHP plan,
Page 108 of the Humana HDHP 08 plan,
Page 110 of the Humana PPO 08 plan, and
Page 110 of the Humana Coverage First 08 plan reflect:

> GLOSSARY

> **Family member** means *you or your spouse, or your or your spouse's child, brother, sister, or parent.* [Emphasis added.]

Page 34 of the Basic PPO Limited Mandate Plan,
Page 27 of the Basic Indemnity Plan,
Page 28 of the Standard Indemnity Plan, and
Page 35 of the Standard PPO Plan reflect:

> DEFINITIONS
>
> Immediate Family means an insured person's mother, father, sister, brother, spouse, or child(ren).

Page 46 of the HDHP plan,
Page 45 of the Humana HDHP 08 plan,
Page 47 of the Humana PPO 08 plan,
Page 47 of the Humana Coverage First 08 plan,
Page 15 of the Basic PPO Limited Mandate Plan,
Page 27 of the Basic Indemnity Plan,
Page 28 of the Standard Indemnity Plan, and
Page 35 of the Standard PPO Plan, reflect:

> COVERED EXPENSES
>
> Hospice
>
> - Bereavement support services *for the hospice patient's family* during the twelve month period following death. The maximum benefit payable for this service is $1,150. [Emphasis added.]

Form Name	Form Number	Marketed
HDHP Plan	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
CO Basic PPO Limited Mandate	CO-57315-07 E BPC	06/01/09 - 10/31/09
CO Basic Indemnity Plan	CO-57315-07BIN 3/2008	06/01/08 to current
CO Standard Indemnity Plan	CO-57315-07 E SIC	06/01/06 to current
CO Standard PPO Plan	CO-57315-07 E SPC	06/01/08 to current

HIC's individual policies reviewed are not in compliance with Colorado insurance law in that the benefits for home health services and hospice care are not correct or complete in the following ways:

Incorrect

(1) The policies exclude services by a licensed pastoral counselor to a member of his/her congregation. This appears to be more limiting than allowed by Colorado insurance law as the

policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services; nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, (e.g., services for a member of their congregation).

(2) The policies reflect an incorrect definition of an "immediate family" as it relates to benefits to be provided for bereavement services which are a requirement for hospice care. The definition of a patient's family is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties.

Incomplete

(1) The policies reflect that Home Health Services are to be provided at the covered person's home. These services are to be provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

(2) Nothing is reflected in the policies indicating that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

(3) The policies do not reflect the 'inpatient hospice respite care" as a level of care to be provided on an intermittent, non-routine, short-term basis.

Page 31 of the Short Term Medical-STM 100/75 Policy,
Page 41 of the IMM-OV Copay Policy,
Page 36 of the AMP 250K, 75/55, 5K Policy,
Page 41 of the Monogram, IMM 100Rx, (No Supplemental Accident Benefit) Policy,
Page 52 of the Monogram, IMM 100 Rx, (SAB of $1,000) Policy,
Page 41 of the Autograph, HSAQ 100 Rx, (Single Deductible of $2,500 and Lifetime Max of $5,000,000) Policy,
Page 37 of the Autograph, HSAQ 100, (Single Deductible of $5,200 and Lifetime Max of $2,000,000) Policy,
Page 51 of the Autograph, HSAQ 100 Rx, (Single Deductible of $5,000 and Lifetime Max of $5,000,000) Policy,
Page 41 of the Portrait IMM, (RX deductible of $500 and no SAB) Policy,
Page 41 of the Portrait IMM, (No RX deductible) Policy, and
Page 41 of the Portrait IMM, ($1,000 SAB) Policy reflect:

LIMITATIONS AND EXCLUSIONS

Hospice exclusions

Services by a licensed pastoral counselor to a member of his/her congregation; (short term policy) or

Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister.

Page 46 of the Short Term Medical-STM 100/75 Policy,
Page 26 of the IMM-OV Copay Policy,
Page 22 of the AMP 250K, 75/55, 5K Policy,
Page 26 of the Monogram, IMM 100Rx, (No Supplemental Accident Benefit) Policy,
Page 31 of the Monogram, IMM 100 Rx, (SAB of $1,000) Policy,
Page 26 of the Autograph, HSAQ 100 Rx, (Single Deductible of $2,500 and Lifetime Max of $5,000,000) Policy,
Page 25 of the Autograph, HSAQ 100, (Single Deductible of $5,200 and Lifetime Max of $2,000,000) Policy,
Page 30 of the Autograph, HSAQ 100 Rx, (Single Deductible of $5,000 and Lifetime Max of $5,000,000) Policy,
Page 26 of the Portrait IMM, (RX deductible of $500 and no SAB) Policy,
Page 26 of the Portrait IMM, (No RX deductible) Policy, and
Page 26 of the Portrait IMM, ($1,000 SAB) Policy reflect:

POLICY DEFINITIONS (short term policy)

F

Family member means the *covered person* or the *covered person's* spouse, or the *covered person* or their spouse's child, brother, sister or parent.

COLORADO RIDER (base plan rider with short term policy and AMP policy)

Hospice
Bereavement support services for the family of the deceased *covered person* during the 12-month period following the date of death.

YOUR POLICY BENEFITS

Hospice Care or
Hospice care

- Bereavement *services* for the family for the twelve month period following death. (this sentence not included in the AMP 250K, 75/55,5K policy)

For this benefit only, immediate family is considered to be the *covered person's* parent, spouse and children or step-children.

Page 18 of the Short Term Medical-STM 100/75 Policy,
Page 25 of the IMM-OV Copay Policy,
Page 22 of the AMP 250K, 75/55, 5K Policy,
Page 25 of the Monogram, IMM 100Rx, (No Supplemental Accident Benefit) Policy,
Page 30 of the Monogram, IMM 100 Rx, (SAB of $1,000) Policy,
Page 25 of the Autograph, HSAQ 100 Rx, (Single Deductible of $2,500 and Lifetime Max of $5,000,000) Policy,
Page 24 of the Autograph, HSAQ 100, (Single Deductible of $5,200 and Lifetime Max of $2,000,000) Policy,

Page 29 of the Autograph, HSAQ 100 Rx, (Single Deductible of $5,000 and Lifetime Max of $5,000,000) Policy,
Page 25 of the Portrait IMM, (RX deductible of $500 and no SAB) Policy,
Page 25 of the Portrait IMM, (No RX deductible) Policy, and
Page 25 of the Portrait IMM, ($1,000 SAB) Policy reflect:

> **Home healthcare** or
> **Home Health Care**
>
> - *Services* provided by a *home healthcare provider*, at the *covered person's* home, under a *home healthcare plan* to include:

Form Name	Form Number	Marketed
Short Term Medical-STM 100/75	GN-71008-01 1/2008	3/6/09 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 13:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-8, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect the complete and correct extent of coverage to be provided for home health services and hospice care as required by Colorado insurance law.

Issue E10: Failure to reflect in the Basic and Standard Plans a correct definition of and the coverage to be provided for emergency care.

Colorado Insurance Regulation 4-6-5 (effective January 1, 2008), 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. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three 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 § 10-16-108, C.R.S. [Emphasis added.]

…

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

Colorado Division of Insurance
Effective 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". [Emphasis added.]

Benefit Grid

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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	BASIC PPO PLAN
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	
15. EMERGENCY CARE [12, 13]	$250 copay then carrier pays 70% coinsurance (No deductible)
	BASIC INDEMNITY PLAN
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	
15. EMERGENCY CARE [12, 13]	50% coinsurance

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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD PPO PLAN
15. EMERGENCY CARE [12, 13]	$150 copay then plan pays 80% coinsurance (No deductible)

	STANDARD INDEMNITY PLAN
15. EMERGENCY CARE [12, 13]	80% coinsurance

12 "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

13 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

Emergency Insurance Regulation 4-6-5 (effective November 4, 2008 with benefits effective January 1, 2009), 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. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three 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 § 10-16-108, C.R.S. [Emphasis added.]

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

Colorado Division of Insurance
Effective January 1, 2009

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". [Emphasis added.]

Benefit Grid

JANUARY 1, 2009 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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	BASIC PPO PLAN
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	
15. EMERGENCY CARE [12, 13]	$250 copay then carrier pays 70% coinsurance (No deductible)
	BASIC INDEMNITY PLAN
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	
15. EMERGENCY	

CARE [12, 13]	50% coinsurance

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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD PPO PLAN
15. EMERGENCY CARE [12, 13]	$150 copay then plan pays 80% coinsurance (No deductible)

	STANDARD INDEMNITY PLAN
15. EMERGENCY CARE [12, 13]	80% coinsurance

12 "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

13 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

Colorado Insurance Regulation 4-6-5 (effective February 1, 2009), 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. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three 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 § 10-16-108, C.R.S. [Emphasis added.]

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

Colorado Division of Insurance
Effective February 1, 2009

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". [Emphasis added.]

Benefit Grid

FEBRUARY 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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	BASIC PPO PLAN
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	
15. EMERGENCY	$250 copay then carrier pays

CARE [12, 13]	70% coinsurance (No deductible)
	BASIC INDEMNITY PLAN
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	
15. EMERGENCY CARE [12, 13]	50% coinsurance

FEBRUARY 1, 2009 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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD PPO PLAN
15. EMERGENCY CARE [12, 13]	$150 copay then plan pays 80% coinsurance (No deductible)

	STANDARD INDEMNITY PLAN
15. EMERGENCY CARE [12, 13]	80% coinsurance

12 "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

13 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

Three (3) of the Basic and Standard Health Benefit Plans reviewed are not in compliance with Colorado insurance law in that the coverage provided for non-emergency conditions delivered in a hospital emergency room is more limiting than allowed. The Limitations and Exclusions section of the plans limit the coverage to care that has been authorized by HIC. Coverage is to be provided if the person receiving such care was referred to the emergency room by *his/her carrier or primary care physician*. [Emphasis added.]

Page 59 of the Basic PPO Limited Mandate Plan,
Page 50 of the Basic Indemnity Limited Mandate Plan, and
Page 60 of the Standard PPO Plan reflect:

MEDICAL BENEFITS – LIMITATIONS AND EXCLUSIONS

- Care for non-emergency conditions delivered in a Hospital Emergency Room or emergency transportation services, unless authorized by **Us**;

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Plan	CO-57315-07 E BC	06/01/09 to current
CO Basic Indemnity Limited Mandate Plan	CO-57315-07 BAS E LE	06/01/08 to current
Standard PPO Health Benefit Plan	CO-57315-07 STD LE	06/01/08 to current

Additionally, HIC's Basic and Standard plans reviewed are not in compliance with Colorado insurance law in that they exclude coverage for services received in an emergency room unless required because of an emergency medical condition. This exclusion is more limiting than allowed by Colorado insurance law as:

(1) A plan must cover this type of care if a prudent lay person would have believed that an emergency medical condition or life or limb threatening emergency existed and

(2) Non-emergency care delivered in an emergency room only requires that the person receiving such care was referred by his/her carrier or primary care physician.

Page 82 of the Basic Limited Mandate PPO Plan,
Page 73 of the Basic Limited Mandate Indemnity Plan,
Page 81 of the Standard PPO Plan, and
Page 74 of the Standard Indemnity Plan reflect:

AMENDMENT

This amendment is made part of the group policy to which it is attached. The effective date of this change is the latter of the effective date of the group policy or the date this amendment is added to the group policy.

LIMITATIONS AND EXCLUSIONS

The following exclusion is added to the group policy:

Services received in an emergency room unless required because of an emergency medical condition.

This exclusion also appears to be in conflict with the definition of "emergency care" in the plans.

Page 30 of the Basic PPO Limited Mandate Plan,
Page 23 of the Basic Indemnity Limited Mandate Plan,
Page 29 of the Standard PPO Plan, and
Page 24 of the Standard Indemnity Plan reflect:

Emergency Care means **Medically Necessary Services** for the care of a sudden, and at the time, unexpected onset of a health condition that a prudent lay person would

assume requires immediate medical attention and where failure to provide immediate medical attention would result in:

- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part; or
- Placing **Your** health in serious jeopardy

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Plan	CO-57315-07 E BPC	06/01/09 - 10/31/09
CO Basic Indemnity Limited Mandate Plan	CO-57315-07BIN 3/2008	06/01/08 to current
CO Standard Indemnity Plan	CO-57315-07 E SIC	06/01/06 to current
CO Standard PPO Plan	CO-57315-07 E SPC	06/01/08 to current

Recommendation No. 14:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms with regard to the definition of emergency care and the guidelines under which it is to be covered as required by Colorado insurance law.

Issue E11: Failure to provide reimbursement for covered services when lawfully performed by a licensed provider that either resides in the insured's home or who is a family member. (*This was prior Issue E6 in the final 2002 examination report*).

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*. … [Emphasis added.]

HIC's small group plans and individual policies reviewed reflect an exclusion that does not appear to be in compliance with Colorado insurance law by excluding coverage for services performed by a provider who is a member of the covered person's family. A policy may contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services; nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, (e.g., a family member or resides in the covered person's home).

Pages 58, 59 & 60 of HIC's four (4) small group plans reviewed reflect:

Limitations and Exclusions (Continued)

Other limitations and exclusions

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

- Medical services provided by a *covered person's family member*.

Form Name	Form Number	Marketed
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current

Page 30 of the Short Term Medical Policy,
Page 40 of the IMM-OV Copay Policy,
Page 35 of the AMP 250K, 75/55, 5K Policy,
Page 40 of the Monogram, IMM 100Rx Policy (No Supplemental Accident Benefit),
Page 51 of the Monogram, IMM 100 Rx Policy (SAB of $1,000),
Page 40 of the Autograph, HSAQ 100 Rx Policy (Single Deductible of $2,500 and Lifetime Max of $5,000,000),
Page 36 of the Autograph, HSAQ 100 Policy (Single Deductible of $5,200 and Lifetime Max of $2,000,000),
Page 50 of the Autograph, HSAQ 100 Rx Policy (Single Deductible of $5,000 and Lifetime Max of $5,000,000),
Page 40 of the Portrait IMM Policy (RX deductible of $500 and no SAB),
Page 40 of the Portrait IMM Policy (No RX deductible), and
Page 40 of the Portrait IMM Policy ($1,000 SAB) reflect:

LIMITATIONS AND EXCLUSIONS

Healthcare practitioner and healthcare treatment facility limitations

- *Services*

Provided by a *family member* or person who resides with the *covered person*

Page 47 of the Short Term Medical Policy,
Page 63 of the IMM-OV Copay Policy,
Page 57 of the AMP 250K, 75/55, 5K Policy,
Page 63 of the Monogram, IMM 100Rx Policy (No Supplemental Accident Benefit),
Page 79 of the Monogram, IMM 100 Rx, Policy (SAB of $1,000),
Page 63 of the Autograph, HSAQ 100 Rx Policy (Single Deductible of $2,500 and Lifetime Max of $5,000,000),
Page 58 of the Autograph, HSAQ 100 Policy (Single Deductible of $5,200 and Lifetime Max of $2,000,000),
Page 78 of the Autograph, HSAQ 100 Rx Policy (Single Deductible of $5,000 and Lifetime Max of $5,000,000),
Page 63 of the Portrait IMM Policy (RX deductible of $500 and no SAB),
Page 63 of the Portrait IMM Policy (No RX deductible), and
Page 63 of the Portrait IMM Policy ($1,000 SAB) reflect:

POLICY DEFINITIONS or

MEDICAL GLOSSARY

Healthcare practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license. A *healthcare practitioner's services* are not covered if the practitioner resides in the *covered person's* home or is a *family member*.

Form Name	Form Number	Marketed
Short Term Medical-STM 100/75	GN-71008-01 1/2008	3/6/09 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03-Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08-Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No SAB-Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 15:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to remove the exclusion reimbursing licensed providers who are family members or reside in the covered person's home and to update the definition of "Health Care Practitioner" as required by Colorado insurance law.

In the market conduct examination for the period January 1, 2002 through December 31, 2002, HIC was cited for failure to provide benefits for covered services when lawfully performed by a licensed provider that either resided in the insured's home or who was a family member. The violation resulted in Recommendation #15 of Final Agency Order O-04-056 that HIC should ensure that it revised all affected forms to eliminate exclusions for covered services when provided by a licensed provider who resided in the home of the covered person or who was a family member. Failure to comply with the previous order of the Commissioner may constitute a willful violation of § 10-3-1104, C.R.S.

Issue E12: Failure, in some instances, to reflect correct or complete outpatient coverage benefits to be provided for treatment of alcoholism.

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

…

(9) Availability of coverage for alcoholism.

(a) Any other provision of law to the contrary notwithstanding, no hospitalization or medical benefits contract on a group basis issued by an insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 of this article shall be sold in this state unless the policyholder under such contract or persons holding the master contract under such contract are offered the opportunity to purchase coverage for benefits for the treatment of and for conditions arising from alcoholism, *which benefits are at least equal to the following minimum requirements*: [Emphasis added.]

…

(b) *Outpatient benefits shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished by*: [Emphasis added.]

(I) An accredited or licensed hospital; or

(II) Any public or private facility or portion thereof providing services especially for the treatment of alcoholics, which is licensed by the department of human services for those purposes; or

(III) Any mental health facility approved as such by the department of human services.

HIC's HDHP small group plan is not in compliance with Colorado insurance law as it reflects that outpatient therapy and office therapy individual and group sessions for alcohol dependency are limited to a maximum of -0- per year. There is a table underneath this statement that contradicts it by reflecting percentages of the benefits payable after a deductible for outpatient care and office therapy for alcohol dependency; however, nothing is indicated concerning the statutory requirement of coverage to the extent of five hundred dollars over a twelve-month period.

The Covered Expenses section of the plan indicates benefits for outpatient care and office therapy services will be paid for mental health services and chemical dependency services, but does not mention outpatient benefits for treatment of alcohol dependency.

Page 32 of the HDHP small group plan reflects:

SCHEDULE OF BENEFITS – BEHAVIORAL HEALTH

Alcohol dependence

Outpatient care and office therapy

Outpatient therapy and office therapy individual and group sessions for alcohol dependency are limited to a maximum of 0 per *year*.

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *non-network provider deductible*

Page 52 of the HDHP small group plan reflects:

COVERED EXPENSES – BEHAVIORAL HEALTH

Outpatient care and office therapy services

We will pay benefits for *covered expense* incurred by you for *mental health services* and *chemical dependency* services while not *confined* in a *hospital* or *health care treatment facility* for *outpatient* services, including *outpatient* services provided as part of an *intensive outpatient program*.

Covered expense does not include charges for *outpatient* services rendered in or by a *residential treatment facility*.

The "Schedule of Benefits – Behavioral Health" reflects the benefit limitations for *outpatient* care, including *outpatient* services provided as part of an *intensive outpatient program*, for *mental health services* and *chemical dependency* services, if any.

Form Name	Form Number	Marketed
HDHP Plan	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07

Recommendation No. 16:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms with regard to the outpatient benefits to be provided for treatment of alcoholism as required by Colorado insurance law.

Issue E13: Failure, in some instances, to reflect correct requirements for emergency admission notification.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

> (1) A carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:
>
> **…**
>
> (5) A managed care plan *shall not deny benefits for emergency services* previously rendered, *based upon the covered person's failure to provide subsequent notification in accordance with plan provisions, where the covered person's medical condition prevented timely notification*.

HIC's Basic and Standard Health Benefit Plans reflect a notification requirement for emergency admissions that is more limiting than Colorado insurance law in that the plan provisions, as reflected, do not provide for those instances where the medical condition prevents the covered person from meeting HIC's 48 hour (or first business day after the emergency) notification requirement.

Page 10 of the Basic PPO Limited Mandate Plan,
Page 5 of the Basic Indemnity Health Benefit Plan,
Page 6 of the Standard Indemnity Health Benefit Plan, and
Page 12 of the Standard PPO Health Benefit Plan reflect:

SCHEDULE AND DESCRIPTION OF MEDICAL BENEFITS

(CONTINUED)

> **PRESERVICE NOTIFICATION/PREAUTHORIZATION REQUIREMENTS**
>
> **You** or **Your Qualified Practitioner** must contact **Us** by telephone or in writing: ***We*** *must be notified of any* <u>*emergency admission*</u> *within 48 hours after the admission, or by the* end of the first business day following the emergency, whichever is later.
> …
>
> **Preservice Notification** is required prior to a **Confinement**, non-emergency Out-patient **Surgery** *or within 48 hours of an* <u>*emergency admission*</u> *or by the end of the first business day following the emergency,* whichever is later. If **Preservice Notification** is not received, benefits will NOT be payable for the first $500 of **Covered Expense**. [Emphases added.]

Page 50 of the Basic PPO Limited Mandate Plan,
Page 41 of the Basic Indemnity Health Benefit Plan,
Page 42 of the Standard Indemnity Health Benefit Plan, and

Page 51 of the Standard PPO Health Benefit Plan reflect:

> **UTILIZATION MANAGEMENT**
>
> **PRESERVICE NOTIFICATION PROCEDURES**
>
> WHAT YOU ARE REQUIRED TO DO:
>
> . . .
>
> **We** must be notified of any *emergency admission* within 48 hours after the admission, or by the end of the first business day following the emergency, whichever is later.

Page 52 of the Basic PPO Limited Mandate Plan,
Page 43 of the Basic Indemnity Health Benefit Plan,
Page 44 of the Standard Indemnity Health Benefit Plan, and
Page 53 of the Standard PPO Health Benefit Plan reflect:

> **FAILURE TO MEET PRESERVICE NOTIFICATION/PREAUTHORIZATION REQUIREMENTS**
>
> **Preservice Notification** is required prior to a **Confinement**, non-emergency Out-patient Surgery, or within 48 hours of an *emergency admission*. If **Preservice Notification** is not provided, benefits will NOT be payable for the first $500 of **Covered Expense**.

Form Name	Form Number	Effective Date
CO Basic PPO Limited Mandate	CO-57315-07 E BPC	06/01/09 - 10/31/09
CO Basic Indemnity Plan	CO-57315-07BIN 3/2008	06/01/08 to current
CO Standard Indemnity Plan	CO-57315-07 E SIC	06/01/06 to current
CO Standard PPO Plan	CO-57315-07 E SPC	06/01/08 to current

Recommendation No. 17:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to be in compliance with Colorado insurance law with regard to notification requirements for emergency admissions.

Issue E14: Failure, in some instances, to reflect correct benefits for mammograms.

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. Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. The routine and diagnostic coverages provided pursuant to this subsection (4) shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy*. … [Emphasis added.]

Three (3) of HIC's small group plans are not in compliance with Colorado insurance law in that the Schedule of Benefits reflects that a non-network deductible will be applied to the benefit payable for preventive mammograms when using non-network health care practitioners. Additionally, the Standard Indemnity Health Benefit Plan reflects under "Preventive Care" that coverage for mammograms will be payable at a flat 80% instead of the lesser of the minimum benefit required that is adjusted to reflect increases and decreases in the consumer price index, or the actual charge for such screening.

Additionally, the small group plans reviewed are not in compliance with Colorado insurance law as nothing is reflected in the plans as to whether benefits shall be determined on a calendar year or a contract year or to indicate that this benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy.

Ten (10) of HIC's individual policies are not in compliance with Colorado insurance law in that an incorrect description of the required coverage is reflected for mammograms for both network and non-network providers. There is a minimum benefit amount required under Colorado insurance law and this

benefit, for the period of this examination, was adjusted annually on September 1, to reflect increases and decreases in the consumer price index. Coverage for mammography shall be the lesser of this minimum benefit amount or the actual charge and is not to be determined by using coinsurance that could reduce the benefit below the minimum mandated benefit amount. Additionally, to exclude coverage for non-network providers of mammography screenings is not allowed by Colorado insurance law.

The minimum benefit amount for mammography was as follows for the time periods indicated:

September 1, 2007: $92.73
September 1, 2008: $96.16

The Colorado Rider which is a base plan rider with the AMP 250K, 75/55, 5K individual policy reflects:

COLORADO RIDER

Mammography

Coverage is available for routine mammograms as follows:

- A single mammogram for a female *covered person* between the ages of 35 to 40;
- One mammogram every 2 years for a female *covered person* between the ages of 40 to 50; and
- Annually for a female *covered person* between the ages of 50 to 65.

Benefits for mammograms are payable under this *policy* the same as any other *sickness* subject to a maximum of $60.00 per screening or the actual screening charge, whichever is less. *Covered expenses* are subject to all *policy* requirements including but not limited to any *coinsurance out-of-pocket limits* and *policy* maximums and are exempt from the *deductible* requirement and the preventive care waiting period and benefit maximum.

Page 16 of the Humana HDHP 08 plan and
Page 17 of the Humana Coverage First 08 plan reflect:

SCHEDULE OF BENEFITS

Preventive mammogram

Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Page 17 of the Humana PPO 08 plan reflects:

Non-network health care practitioner	60% benefit payable after *non-network provider deductible*

Page 15 of the Standard Indemnity Health Benefit Plan reflects:

PREVENTIVE CARE

Covered Expenses for Preventive Care for **Covered Persons** ages 12 and younger and for prostate screenings and mammograms will be payable at 80%

Page 10 of the IMM-OV Copay Policy and
Page 10 of the AMP 250K, 75/55, 5K Policy reflect:

SCHEDULE OF BENEFITS

Routine Services to Include: Exams, Immunizations, Mammograms, Pap Smears and PSA Tests

Network Provider: *You* pay 25% coinsurance, *we* pay 75% of *covered expenses*
Non-Network Provider: Not Covered

Page 10 of the Monogram, IMM 100Rx (No Supplemental Accident Benefit) Policy,
Page 9 of the Monogram, IMM 100 Rx (SAB of $1,000) Policy,
Page 11 of the Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000) Policy,
Page 10 of the Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000) Policy,
Page 8 of the Autograph HSAQ 100 RX (Single Deductible of $5,000 and Lifetime Max of $5,000,000) Policy,
Page 10 of the Portrait IMM (RX Deductible of $500 and no SAB) Policy,
Page 10 of the Portrait IMM (No RX deductible) Policy, and
Page 10 of the Portrait IMM ($1,000 SAB) reflect:

SCHEDULE

13. **Preventive Care or**
14. **Preventive Care or**
15. Preventive Care

C. Mammograms, PSA testing, Digital Rectal Exams, and Child Health Supervision Services to age 13 (page 10) (page 11)

C. Mammograms, PSA testing, Digital Rectal Exams, Colorectal Cancer Screenings, and Child Health Supervision Services to age 13 (page 9)

Non-Network Provider: You pay 25% *coinsurance, we* pay 75% of *covered expenses.*
Non-Network Provider: You pay 30% *coinsurance, we* pay 70% of *covered expenses*
Non-Network Provider: Not covered (page 8)
Network Provider: You pay 20% *coinsurance, we* pay 80% of *covered expenses*
Non-Network Provider: You pay 40% *coinsurance, we* pay 60% of *covered expenses* (page 10)

Form Name	Form Number	Marketed
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
Standard Indemnity Health Benefit Plan	CO-57315-07 E SIN 1/2006	06/01/06 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 18:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect correctly the benefits to be provided for mammography as required by Colorado insurance law.

Issue E15: Failure, in some instances, to allow for other single and multi-organ transplants not specifically listed if they are determined to be medically necessary and meet clinical standards for the procedure.

Colorado Insurance Regulation 4-6-5 (effective January 1, 2008), 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. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three 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 § 10-16-108, C.R.S. [Emphasis added.]

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

Colorado Division of Insurance

Effective 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". [Emphasis added.]

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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

BASIC PPO LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC PPO 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. [Emphasis added.]

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

BASIC INDEMNITY 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. [Emphasis added.]

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

	STANDARD PPO 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. [Emphasis added.]

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

Emergency Insurance Regulation 4-6-5 (effective November 4, 2008 with benefits effective January 1, 2009), 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. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three 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 § 10-16-108, C.R.S. [Emphasis added.]

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

Colorado Division of Insurance

Effective January 1, 2009

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". [Emphasis added.]

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, 2009 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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

BASIC PPO LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC PPO 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. [Emphasis added.]

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

BASIC INDEMNITY LIMITED	BASIC INDEMNITY PLAN

MANDATE HEALTH BENEFIT 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. [Emphasis added.]

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

	STANDARD PPO 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. [Emphasis added.]

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

Colorado Insurance Regulation 4-6-5 (effective February 1, 2009), 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. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three 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 § 10-16-108, C.R.S. [Emphasis added.]

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

Colorado Division of Insurance

Effective February 1, 2009

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". [Emphasis added.]

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".

February 1, 2009 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 the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

BASIC PPO LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC PPO 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. [Emphasis added.]

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

BASIC INDEMNITY 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. [Emphasis added.]

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

	STANDARD PPO 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. [Emphasis added.]

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

HIC's Basic and Standard plans are not in compliance with Colorado insurance law in that the coverage for mandated organ transplants is more limiting than allowed by law. Benefits are required to be provided for "other single and multi-organ transplants" in addition to the specific transplants that are listed in the benefit grid for these plans.

An all encompassing exclusion as stated in the policy for certain types of organ transplants does not allow a decision to be made concerning the medical necessity of, or whether clinical standards are met for the transplant procedures as is required by Colorado insurance law.

Page 60 of the Basic PPO Limited Mandate Plan,
Page 51 of the Basic Indemnity Limited Mandate Plan,
Page 59 of the Standard PPO Plan, and

Page 52 of the Standard Indemnity Plan reflect:

MEDICAL BENEFITS – LIMITATIONS AND EXCLUSIONS

- Confinement, treatment or service for:

- Human to human organ transplants except for those otherwise indicated in this certificate;
- Animal-to-human organ transplants; or
- Implantation within the human body of artificial or mechanical devices designed to replace human organ(s)

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Health Benefit Plan	CO-57315-07 E BC	06/01/09 to 10/31/09
CO Basic Indemnity Limited Mandate Health Benefit Plan	CO-57315-07 BAS E LE	06/01/08 to current
Standard PPO Health Benefit Plan	CO-57315-07 STD LE	06/01/08 to current
Standard Indemnity Health Plan	CO-57315-07 E STD LE	06/01/06 to current

Recommendation No. 19:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to indicate that single and multi-organ transplants other than those specifically listed may be covered if they are medically necessary and meet clinical standards for the procedure as required by Colorado insurance law.

Issue E16: Failure, in some instances, to reflect correct pre-existing 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:

. . .

(c) Shall exclude coverage *for late enrollees* for the greater of twelve months or for *no more than an eighteen-month-preexisting condition exclusion*; except that, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan. Health maintenance organizations that do not use preexisting condition exclusion periods in any of their plans may impose up to a three-month affiliation period in lieu of the eighteen-month preexisting condition period. [Emphases added.]

Section 10-16-214, C.R.S., Group sickness and accident insurance, states in part:

…

(3) (a) Except as provided for in subsection (2) of this section, all policies of group sickness and accident insurance providing coverage to persons residing in the state shall contain in substance the following provisions or provisions which, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

…

(V)(B) *In no event shall such exclusion or limitation apply* to loss incurred or disability commencing after the earlier of the end of a *continuous period of six months* commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition and the end of the six-month period commencing on the effective date of the person's coverage, except as provided in sub-subparagraphs (A) and (C) of this subparagraph (V). [Emphases 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 §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

…

Section 5. Rules

…

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

Colorado law *prohibits group health plans* from imposing a pre-existing condition limitation period *that exceeds six (6) months*, except with respect to late enrollees as provided for in Section 10-16-118(1)(c), C.R.S. All references in the federal regulations to twelve (12) month pre-existing condition limitations for group health benefit plans are not applicable in Colorado. [Emphasis added.]

HIC's small group plans are not in compliance with Colorado insurance law in that they include an incorrect time period of twelve (12) months that an individual may be subject to a preexisting condition limitation. Colorado insurance law provides that an individual will not be subject to pre-existing condition limitations if there was continuous creditable coverage for an aggregate period of six (6) months. For late entrants, Colorado insurance law mandates a maximum combined time period of eighteen months in the event that both a period of exclusion from coverage and a pre-existing condition exclusion apply.

Page 57 of the HDHP plan,
Page 56 of the Humana HDHP 08 plan,
Page 58 of the Humana PPO 08 plan, and
Page 58 of the Humana Coverage First 08 plan reflect:

LIMITATIONS AND EXCLUSIONS

Pre-existing condition limitation

The *pre-existing condition* limitation shall not be applied to *you* if *you* were continuously covered for an aggregate period of twelve months under *creditable coverage.*

Form Name	Form Number	Marketed
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current

Recommendation No. 20:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of §§ 10-16-118 and 10-16-214, C.R.S. and Colorado Insurance Regulation 4-2-18, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect a correct description of pre-existing condition limitations as required by Colorado insurance law.

Issue E17: Failure to reflect correct "absence from work" termination of coverage provisions in Basic and Standard plans.

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

…

(2) Continuation of policies and group service contracts – reduction in hours of work. Every group policy or group service contract delivered or issued for delivery in this state by an insurer subject to the provisions of part 2 of this article or by an entity subject to the provisions of part 3 or 4 of this article that covers full-time employees working forty or more hours per week shall contain a provision that *the policyholder may elect to contract with the insurer or other entity to continue such policy or contract under the same conditions and for the same premium for such employees and their dependents even if the policyholder or employer reduces the working hours of such employees to less than thirty hours per week, if the following conditions are met*: [Emphasis added.]

(a) The covered employee is employed as a full-time employee of the policyholder or employer and is insured under the group policy or group service contract, or under any group policy or group service contract providing similar benefits which said group policy or group service contract replaces, immediately prior to such reduction in working hours;

(b) The policyholder has imposed such reduction in working hours due to economic conditions or the reduction of hours is due to the employee's injury, disability, or chronic health conditions; and

(c) The policyholder intends to restore the employee to a full forty-hour work schedule as soon as economic conditions improve or as soon as the employee is able to return to full-time work.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans, - modification of health benefit plans, states in part:

(1) *A carrier providing coverage under a health benefit plan shall not discontinue coverage or refuse to renew such plan except for the following reasons:* [Emphasis added.]

(a) Nonpayment of the required premium;

(b) Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage;

…

(d)(I) The carrier elects to discontinue offering and nonrenew all of its individual, small group, or large group health benefit plans delivered or issued for delivery in this state. …

…

(g) With respect to group health benefit plans, the policyholder fails to comply with participation or contribution rules;

(h) With respect to a carrier that offers group health benefit plans in the market through a managed care plan, there is no longer any enrollee in connection with such plan that lives, resides, or works in the service area of the carrier;

(i) With respect to small group health benefit plans, an employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan;

HIC's Basic and Standard plans are not in compliance with Colorado insurance law in that stated conditions of "Special Provisions For Absence From Work" is more limiting than allowed under Colorado insurance law for termination of coverage by the carrier. The policy shall contain a provision that the policyholder may elect to contract with the insurer or other entity to continue such policy or contract under the same conditions and for the same premium even if the policyholder reduces the working hours of such employees to less than thirty hours per week if certain conditions are met. There is no provision in Colorado insurance law to limit this or an employer approved leave of absence to a maximum of three (3) consecutive months. Additionally, an employee in part-time status could still meet the definition of an eligible employee if he or she had a regular work week of at least twenty-four (24) hours.

Page 43 of the Basic PPO Limited Mandate Plan,
Page 36 of the Basic Indemnity Limited Mandate Plan,
Page 42 of the Standard PPO Plan, and
Page 37 of the Standard Indemnity Plan reflect:

SPECIAL PROVISIONS FOR ABSENCE FROM WORK

If the **Employer** continues to pay required premiums and continues participation under this Policy, **Your** coverage will remain in force for no longer than three consecutive months if the **Employee** is:

- Temporarily laid-off;
- In part-time status; or
- On an **Employer** approved leave of absence

If this coverage terminates, the **Employee** may exercise the rights under any applicable Continuation of Medical Benefits provision, or the Medical Conversion Privilege described in this Certificate. If the **Employee** utilizes the Conversion Privilege, he or she thereby waives the right to continue coverage. If the **Employee** returns to work on a regular basis, he or she will be considered a new **Employee** and must re-enroll for Employee Coverage.

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Health Benefit Plan	CO-57315-07 E BC	06/01/09 to current
CO Basic Indemnity Limited Mandate Health Benefit Plan	CO-57315-07 BAS E LE	06/01/08 to current
Standard PPO Health Benefit Plan	CO-57315-07 STD LE	06/01/08 to current

Standard Indemnity Health Plan	CO-57315-07 E STD LE	06/01/06 to current

Recommendation No. 21:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of §§ 10-16-108 and 10-16-201.5, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms with regard to the "Absence from Work" termination of coverage provisions as required by Colorado insurance law.

Issue E18: Failure, in some instances, to reflect the correct procedures for conducting utilization review.

Section 10-16-113, C.R.S., Procedure for denial of benefits – internal review – rules, states in part:

. . .

(1)(b) For the purpose of this section, a denial of a preauthorization for a covered benefit shall be considered a denial of a request for benefits and shall be made pursuant to the provisions of this section.

. . .

(2) Following a denial of a request for benefits by the health coverage plan, such plan shall notify the covered person in writing. The content of such notification *and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner*. [Emphasis added.]

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 [1]

. . .

M. "Prospective review" means utilization review conducted prior to an admission or course of treatment.

. . .

O. "Retrospective review" means any utilization review that is not prospective review, but does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

. . .

S. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Section 5 Compliance Requirements

. . .

C. A health carrier that does not investigate claims involving utilization review within the time frames set out in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly investigate claims. (Section 10-3-1104(1)(h)(II), C.R.S.)

Section 6 Standard Utilization Review

. . .

B. Prospective review determinations.

1. Time period for determination and notification.

a. Subject to Subparagraph b. of Paragraph 1., a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request. Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection E.

b. The time period for making a determination and notifying the covered person of the determination pursuant to Subparagraph a. of Paragraph 1. may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:

(i) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(ii) Notifies the covered person prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

c. If the extension under Subparagraph b. of Paragraph 1. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:

. . .

(ii) Give the covered person at least forty-five (45) days from the date of receipt of the notice to provide the specified information.

. . .

1. For an adverse determination regarding a prospective review decision that occurs during a covered person's hospital stay or course of treatment, the health care service or treatment that is the subject of an adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the carrier.

C. Retrospective review determinations.

1. For retrospective review determinations, a health carrier shall make the determination *and notify the covered person and the covered person's provider of the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request*. If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection E. [Emphasis added.]

2. Time period for determination and notification.

. . .

b. If the extension under Subparagraph a. of Paragraph 2. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:

(i) Specifically describe the required information necessary to complete the request; and

(ii) *Give the covered person at least thirty (30) days from the date of receipt of the notice to provide the specified information*. [Emphasis added.]

. . .

Section 10 First Level Review

. . .

D. *Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to Section 6 or 7* or after the receipt of notification of a benefit denied due to a contractual exclusion, *a covered person may file a grievance with the health carrier requesting a first level review of the adverse determination.* In order to secure a first level review after the receipt of the notification of a benefit denied due to a contractual exclusion, the covered person must be able to provide written evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply. [Emphases added.]

HIC's Basic and Standard plans are not in compliance with Colorado insurance law in that utilization review provisions reflected in the plan are incorrect. The time periods for submitting requests for review of an adverse determination, for making a determination and for notification of the determination indicate time periods using "working" days instead of "calendar" days and an incorrect number of days is reflected for a covered person to submit additional information regarding preauthorization/preservice review and retrospective review.

Preauthorization

1. If additional information is required to make a determination, the covered person is to be given at least forty-five (45) calendar days from the date of receipt of the notice to provide the specified information not 20 days as reflected in the plan.

Concurrent Review

1. A determination, whether it is an adverse determination or not, with respect to a request for concurrent urgent care is to be made no more than twenty-four (24) hours after the health carrier's receipt of the request. The plan states the notification time frame of one (1) working day of the determination and it would have to be one (1) calendar day of the determination to be in compliance.

Retrospective Review

(1) For retrospective review determinations, a carrier is to make the determination and notify the covered person and the covered person's provider of the determination no later than thirty (30) calendar days, not thirty (30) working days.

(2) If additional information is necessary to reach a determination, a covered person is to be given at least thirty (30) calendar days from the receipt of notice from the carrier to provide the necessary additional information. The certificate reflects twenty (20) days.

Page 51 of the Basic PPO Limited Mandate Plan,
Page 42 of the Basic Indemnity Limited Mandate Plan,
Page 50 of the Standard PPO Plan, and
Page 43 of the Standard Indemnity Plan reflect under **UTILIZATION MANAGEMENT:**

PREAUTHORIZATION

When **Preservice Review** or **Preauthorization** is required, **We** will review all the necessary information within two (2) working days of receiving such information. If an initial determination cannot be made due to a lack of information, ***We*** *will request the information necessary to make the determination within two (2) working days. All information must be received by* ***Us*** *within 20 days of this request.* **We** will make a determination within two working days of the date the information is due or the date the information is received, whichever is earlier. **We** will notify **Your Qualified Practitioner** within 24 hours of making the initial determination and will provide written or electronic confirmation of the determination to **You** and **Your Qualified Practitioner** within two (2) working days. In the case of an adverse determination, **We** will notify **Your Qualified Practitioner** by telephone within one

(1) working day of making the determination and will provide written or electronic confirmation to **You and Your Qualified Practitioner** within one (1) working day.

In the case of an initial determination or concurrent review determination, the **Qualified Practitioner** rendering the **Service**, can request reconsideration of an adverse determination, on **Your** behalf. The reconsideration will occur within one working day of the receipt of such request. If this process does not resolve the difference of opinion, the adverse determination may be appealed. [Italicized emphasis added.]

CONCURRENT REVIEW

In the case of a determination to certify an extended stay or additional **Services, We** will notify the **Qualified Practitioner** rendering the **Service** by telephone within one (1) working day of the determination. Verbal notification will be followed by written or electronic confirmation within one (1) working day. In the case of an adverse determination, notification will be given to the **Qualified Practitioner** by telephone within 24 hours of making the adverse determination. Verbal notification will be followed by written or electronic confirmation within one (1) working day.

Page 52 of the Basic PPO Limited Mandate Plan,
Page 43 of the Basic Indemnity Limited Mandate Plan,
Page 51 of the Standard PPO Plan, and
Page 44 of the Standard Indemnity Plan reflect under **UTILIZATION MANAGEMENT:**

RETROSPECTIVE REVIEW

Within 30 *working* days of receiving all the necessary information, **We** will complete the review. If a determination cannot be made due to a lack of information, **We** will request the information necessary *to make the determination within two (2) working days. All information must be received within 20 days of this request*. [Italicized emphasis added.]

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Health Benefit Plan	CO-57315-07 E BC	06/01/09 to current
CO Basic Indemnity Limited Mandate Health Benefit Plan	CO-57315-07 BAS E LE	06/01/08 to current
Standard PPO Health Benefit Plan	CO-57315-07 STD LE	06/01/08 to current
Standard Indemnity Health Plan	CO-57315-07 E STD LE	06/01/06 to current

HIC's individual policies are not in compliance with Colorado insurance law in that some of the utilization review provisions reflected in the plans are more limiting than allowed. The time periods for determinations to be made and notification of those determinations to be provided to the covered person and the covered person's provider are to be made using "working" days instead of "calendar" days. The sections cited below are for the provisions reflected in the policies that would be more limiting than allowed for the consumers as a result of the use of "working" days instead of "calendar" days.

Page 15 of the Short Term Medical-STM 100/75 Policy,
Pages 18 and 19 of the IMM-OV Copay Policy,
Page 18 of the AMP 250K, 75/55, 5K Policy,
Pages 17 and 18 of the Monogram, IMM 100Rx (No Supplemental Accident Benefit) Policy,
Pages 17 and 18 of the Monogram, IMM 100 Rx (SAB of $1,000) Policy,
Pages 17 and 18 of the Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000) Policy,
Pages 16 and 17 of the Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000) Policy,
Page 17 of the Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000) Policy,
Pages 17 and 18 of the Portrait IMM (RX deductible of $500 and no SAB) Policy,
Pages 17 and 18 of the Portrait IMM (No RX deductible) Policy, and
Pages 17 and 18 of the Portrait IMM ($1,000 SAB) Policy reflect:

> **UTILIZATION MANAGEMENT**
>
> . . .
>
> **Concurrent review or**
> **<u>CONCURRENT REVIEW</u> or**
> **CONCURRENT REVIEW**
>
> *We* will conduct a concurrent review when a *covered person* has received *preauthorization* or a *preservice review*, and during the course of their treatment plan, it is determined that additional *services or an extended stay may be necessary.*
>
> Once *we* receive the request for the additional *services* or extended stay, *we* will evaluate the *services* within the proposed treatment plan and determine if they are *medically necessary. We* will notify the *healthcare practitioner* rendering the additional *services* within 1 working day of making the determination.
>
> In the case of an adverse determination, notification will be given within 24 hours of making the adverse determination. If notification was verbal, it will be followed by written notification within 1 working day.
>
> . . .
>
> **Retrospective review or**
> **<u>RETROSPECTIVE REVIEW</u> OR**
> **RETROSPECTIVE REVIEW**
>
> If the required *preservice review* was not received prior to receiving healthcare *services*, a retrospective review may be conducted after such *services* are provided to a *covered person.*
>
> Within 30 <u>working</u> days of receiving all the necessary information, *we* will make a determination as to whether the *services* were *medically necessary* and are *covered expenses. We* will provide written notice of *our* determination to the *covered person.* [Underlined emphasis added.]

Form Name	Form Number	Marketed
Short Term Medical-STM 100/75	GN-71008-01 1/2008	3/6/09 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Two (2) of HIC's individual policies are not in compliance with Colorado insurance law in that a time limit of sixty (60) days is reflected for covered persons to request a first level review and the correct number of days to be allowed for requesting a first level review is 180.

Page 30 of the Short Term Medical-STM 100/75 Policy and
Page 30 of the AMP 250K, 75/55, 5K Policy reflect:

> **CLAIMS PAYMENT**
>
> **How to challenge our claim decision (appeal rights)**
>
> If a *covered person* disagrees with *our* decision on payment of a particular claim, the *covered person* can request a second review of the claim, also known as an appeal. To request this review, the *covered person* must send *us* a letter requesting a second claim review <u>within 60 days from the time he/she received notice of *our* claim payment decision</u>. The *covered person* may also send any documents or information which are relevant to *our* decision of how to pay the claim. [Underlined emphasis added.]

Form Name	Form Number	Marketed
Short Term Medical-STM 100/75	GN-71008-01 1/2008	3/6/09 to current
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10

Recommendation No. 22:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. and Colorado Insurance Regulation 4-2-17, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms with regard to correct procedures to be used for utilization review as required by Colorado insurance law.

Issue E19: Failure, in some instances, to allow coverage for hearing aids for dependent children under the age of eighteen (18) years.

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

…

(19) Hearing aids for children – legislative declaration.

(a) The general assembly hereby finds and determines that the language development of children with partial or total hearing loss may be impaired due to the hearing loss. Children learn the concept of spoken language through auditory stimuli, and the language skills of children who have hearing loss improve when they are provided with hearing aids and access to visual language upon the discovery of hearing loss. The general assembly therefore declares that providing hearing aids to children with hearing loss will reduce the costs borne by the state, including special education, alternative treatments that would otherwise be necessary if a hearing aid were not provided, and other costs associated with such hearing loss.

(b) *Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, shall provide coverage for hearing aids for minor children who have a hearing loss that has been verified by a physician licensed pursuant to article 36 of title 12, C.R.S., and by an audiologist licensed pursuant to section 12-5.5-102, C.R.S.* The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following: [Emphasis added.]

(I) Initial hearing aids and replacement hearing aids not more frequently than every five years;

(II) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;

(III) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

(c) The benefits accorded pursuant to this subsection (19) shall be subject to the same annual deductible or copayment established for all other covered benefits within the insured's policy and utilization review as provided in sections 10-16-112, 10-16-113, and 10-16-113.5. The benefits shall also be subject to part 7 of this article.

(d) Health benefit plans issued by an entity subject to this part 1 may provide that the benefits required pursuant to this section shall be covered benefits only if the services are deemed medically necessary.

Colorado Insurance Regulation 4-2-30, Concerning the Rules for Complying with Mandated Coverage of Hearing Aids and Prosthetics, promulgated under the authority of § 10-1-109, C.R.S., states in part:

. . .

Section 3 Applicability

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

Section 4 Definitions

. . .

C. "Hearing aid" shall have the same meaning as set forth in § 10-16-102(24.7), C.R.S.

. . .

E. "Minor child" shall have the same meaning as set forth in § 10-16-102(27.3), C.R.S.

Section 5 Rules

A. Hearing aids.

1. For the purposes of § 10-16-104(19), C.R.S., hearing aids do not meet the traditional definition of durable medical equipment; therefore, *any benefits paid for a minor child's hearing aid(s) in accordance with the coverage mandated by Colorado law shall not be used to exhaust a health benefit plan's annual or lifetime durable medical equipment maximum, if any*. [Emphasis added.]

2. *The mandated coverage of hearing aids for a minor child shall be provided subject to the same annual deductible and/or copayment/coinsurance levels established for other covered benefits*. Benefits shall be determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). These benefits are subject to the policy's general annual and/or lifetime maximum benefit amounts. Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S. [Emphasis added.]

3. *The coverage includes the initial assessment, fitting, adjustments, and the required auditory training.* Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the

needs of the child. This requirement shall apply to each hearing aid if the minor child has two hearing aids. [Emphasis added.]

Emergency Insurance Regulation 4-6-5 (effective November 4, 2008 with benefits effective January 1, 2009), 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:

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

Colorado Division of Insurance

Effective January 1, 2009

Benefit Grid

PART B: SUMMARY OF BENEFITS

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

	BASIC PPO PLAN	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	**IN-NETWORK**	**OUT-OF-NETWORK [2]**
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5) **a) Hearing Aids [19a]**	**Benefit level determined by place of service**	**Benefit level determined by place of service**

19a: As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5) **a) Hearing aids [19a]**	**Benefit level determined by place of service**

	STANDARD PPO HEALTH BENEFIT PLAN	
	IN-NETWORK	**OUT-OF-NETWORK [2]**
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)		
a) Spinal manipulation	**80% coinsurance**	**50% coinsurance**
b) Hearing Aids [23a]	**Benefit level determined by place of service**	**Benefit level determined by place of service**

23a: As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19, C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined b y where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

	STANDARD INDEMNITY PLAN
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)	
a) Spinal manipulation	**80% coinsurance**
b) Hearing Aids [23a]	**Benefit level determined by place of service**

23a: As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19, C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined b y where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

Colorado Insurance Regulation 4-6-5 (effective February 1, 2009), 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:

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

Colorado Division of Insurance

Effective February 1, 2009

Benefit Grid

PART B: SUMMARY OF BENEFITS

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

	BASIC PPO PLAN	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	**IN-NETWORK**	**OUT-OF-NETWORK [2]**
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5) **b) Hearing Aids [19a]**	**Benefit level determined by place of service**	**Benefit level determined by place of service**

19a: As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5) **b) Hearing aids [19a]**	**Benefit level determined by place of service**

	STANDARD PPO HEALTH BENEFIT PLAN	
	IN-NETWORK	**OUT-OF-NETWORK [2]**
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5) **c) Spinal manipulation** **d) Hearing Aids [23a]**	**80% coinsurance** **Benefit level determined by place of service**	**50% coinsurance** **Benefit level determined by place of service**

23a: As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19, C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined b y where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided

as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

	STANDARD INDEMNITY PLAN
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)	
c) Spinal manipulation	**80% coinsurance**
d) Hearing Aids [23a]	**Benefit level determined by place of service**

23a: As of January 1, 2009, hearing aids for dependent children under the age of 18 are covered in compliance with § 10-16-104(19, C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined b y where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

HIC's Basic and Standard Plans are not in compliance with Colorado insurance law as they reflect an exclusion for "hearing aids" which is a mandated coverage for a minor child.

Page 60 of the Basic Limited Mandate PPO Plan,
Page 51 of the Basic Limited Mandate Indemnity Plan,
Page 58 of the Standard PPO Health Benefit Plan, and
Page 51 of the Standard Indemnity Health Benefit Plan reflect:

MEDICAL BENEFITS – LIMITATIONS AND EXCLUSIONS

This Policy does NOT provide benefits for:

- Hearing aids, hair prosthesis, hair transplants or implants, and wigs;

HIC's small group plans reviewed are not in compliance with Colorado insurance law as they reflect an exclusion for "hearing aids" which is a mandated coverage for a minor child.

Page 60 of the HDHP plan,
Page 59 of the Humana HDHP 08 plan,
Page 61 of the Humana PPO 08 plan and
Page 61 of the Coverage First 08 plan reflect:

Unless specifically stated otherwise, no benefits will be provided for, or on account of the following items:

LIMITATIONS AND EXCLUSIONS

- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Health Benefit Plan	CO-57315-07 E BC	06/01/09 to current
CO Basic Indemnity Limited Mandate Health Benefit Plan	CO-57315-07 BAS E LE	06/01/08 to current
Standard PPO Health Benefit Plan	CO-57315-07 STD LE	06/01/08 to current
Standard Indemnity Health Plan	CO-57315-07 E STD LE	06/01/06 to current
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current

HIC is not in compliance with Colorado insurance law as the individual policies identified below reflected the following exclusions for "hearing aids", for the period of time from January 1, 2009 until maintenance filings adding this coverage were made with the Division for an effective use date of 5/9/09.

Page 31 of the Short Term Medical Policy,-STM 100/75 and
Page 36 of the AMP 250K, 75/55, 5K Policy, reflect:

LIMITATIONS AND EXCLUSIONS

Preventive care exclusions

Expense incurred that is not for treatment of a *sickness or bodily injury*. This includes but is not limited to:

- Hearing aids

Page 41 of the IMM-OV Copay Policy,
Page 42 of the Monogram Policy, IMM 100Rx (No Supplemental Accident Benefit),
Page 42 of the Autograph Policy, HSAQ 100 Rx, (Single Deductible of $2,500 and Lifetime Max of $5,000,000),
Page 38 of the Autograph Policy, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000),
Page 42 of the Portrait IMM Policy (RX deductible of $500 and no SAB),
Page 42 of the Portrait IMM Policy ($1,000 SAB), and
Page 42 of the Portrait IMM Policy ($1,000 SAB) reflect:

Service Exclusions & Limitations

- Hearing aids, hair prosthesis, hair transplants or implants, and wigs

Form Name	Form Number	Marketed
Short Term Medical-STM 100/75	GN-71008-01 1/2008	3/6/09 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07

AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000))	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 23:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Insurance Regulations 4-2-30 and 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect that coverage is to be provided for hearing aids for dependent children under the age of 18 as required by Colorado insurance law.

Issue E20: Failure, in some instances, to reflect correct coverage provisions for emergency care to be provided.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

. . .

(2)(b)(I) A carrier offering a managed care plan with out-of-network benefits, that is not a health maintenance organization or a health maintenance organization with a point of service plan, may require that a covered person travel a reasonable distance beyond the requirements of subsection (6) of this section for care within an adequate provider network in order to receive services from a participating provider. This paragraph (b) shall only apply if:

. . .

(B) The carrier demonstrates upon request by the commissioner, that the carrier has made unsuccessful good faith efforts to contract with local providers on reasonable terms.

(II) Subparagraph (I) of this paragraph (b) shall not apply to:

(A) Emergency services or primary care providers;

. . .

(f)(I) For the purposes of this subsection (2):

"Balance bill" means the amount that a nonparticipating provider may charge the covered person. Such amount charged equals the difference between the amount paid by the carrier and the amount of the nonparticipating provider's bill charge.

It appears HIC's PPO plans are not in compliance with Colorado insurance law in that the plans indicated below reflect that if an insured needs emergency care and is unable to access care from a PPO provider, benefits will be paid at the Non-Preferred Provider level. In addition, the plans do not address any exceptions to the requirement to use a preferred provider. Emergency care is an exception to the requirement to travel a reasonable distance to obtain services from a participating provider and if paid at non-network levels would also subject the covered person to possible balance billing.

Page 48 of the Basic PPO Limited Mandate Health Benefit Plan and
Page 47 of the Standard PPO Plan reflect:

HOW TO SELECT A PROVIDER

A list of the participating **Hospitals, Qualified Treatment Facilities, Qualified Practitioners** and other providers in **Your** PPO will be given to **You** at the time **Your** coverage becomes effective. This list is subject to change. To confirm that **Your Hospital, Qualified Treatment Facility, Qualified Practitioner** or other

provider is a current participant in **Your** PPO, you must call the number listed on the back of **Your** medical identification card.

If **You** are traveling *or need emergency care and are unable to access care from* ***Your*** *PPO provider, benefits will be paid at the Non-Preferred Provider level*. [Italicized emphasis added.]

Page 7 of the Humana PPO 08 individual coverage plan reflects:

UNDERSTANDING YOUR COVERAGE

Your choice of providers affects your benefits

If you receive services from a *non-network provider, we* will pay benefits at a lower percentage and *you* will pay a larger share of the costs. Since *non-network providers* have not agreed to accept discounted or negotiated fees, they may bill *you* for charges in excess of the *maximum allowable fee. You* will be responsible for charges in excess of the *maximum allowable fee* in addition to any applicable *deductible, coinsurance* and/or *copayment.* Any amount *you* pay to the provider in excess of *your coinsurance* or *copayment* will not apply to *your out-of-pocket limit* or *deductible.*

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Health Benefit Plan	CO-57315-07 E BC	06/01/09 to current
Standard PPO Health Benefit Plan	CO-57315-07 STD LE	06/01/08 to current
Humana PPO 08	CC2003-C	11/25/07 to current

Recommendation No. 24:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect the correct coverage provisions for emergency care as required by Colorado insurance law.

Issue E21: Failure, in some instances, to provide coverage for treatment or benefits as a result of attempted suicide or intentionally self-inflicted injury whether sane or insane.

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

…

(30) "Policy of sickness and accident insurance" means any policy or contract of insurance against loss or expense resulting from the sickness of the insured, or from *the bodily injury or death of the insured by accident*, or both. [Emphasis added.]

Colorado Insurance Bulletin B-4.5, Suicide Exclusions and Exclusions for Intentionally Self-Inflicted Injuries in Health Coverage Policies, states in part:

…

(II) Applicability and Scope

This bulletin is intended for all health carriers that use exclusions for intentionally self-inflicted injuries, including suicide and suicide attempts in their policies.

(III) Division Position

The Division adheres to the opinion of the Colorado courts that suicide, attempted suicide or other acts of self-destruction *committed while insane* are an accident. Those performing the above acts *while insane* are incapable of formulating the intent necessary to categorize the act as intentional. Therefore, health coverage policies that provide coverage for sickness, accidents and illness, either as may be required by law (such as for mental illness) or otherwise, *may not deny coverage for intentional acts committed while insane*. Such exclusions are contrary to law and are void as against public policy. Accordingly, carriers are advised to amend policy language and interpret existing policy language accordingly. [Emphasis added.]

HIC's individual short term medical policy is not in compliance in that it is more limiting than allowed by Colorado insurance law in its exclusion for treatment as a result of attempted suicide or intentionally self-inflicted injury whether sane or insane.

The prevailing view in Colorado courts is that broad exclusions for self-inflicted injuries or suicide attempts may not be applied in instances in which the insured or member was "insane" at the time of injury in sickness and accident policies written in Colorado. See e.g., Continental Casualty Co. v. Maguire, 471 P.2d 636 (Colo. Ct. App. 1970); Metropolitan Life Insur. Co. v. Wright, 480 P.2d 597 (Colo. Ct. App. 1971); Mass. Protective Ass'n v. Daugherty, 288 P. 888 (Colo.1930) (life insurance policy). The reasoning applied by these courts is that injuries sustained in such circumstances are "accidents," not "intentional" acts, since an individual who is insane is incapable of forming the requisite intent.

In addition, Federal HIPAA nondiscrimination provisions, see 29 CFR 2590.702(b)(2)(iii), do not allow "source of injury" (i.e. self-inflicted) exclusions of benefits otherwise provided for treatment of an injury, if that injury results from a medical condition.

Page 32 of the Short Term Medical policy reflects:

LIMITATIONS AND EXCLUSIONS

- Treatment as a result of attempted suicide or intentionally self-inflicted injury whether sane or insane

Form Name	Form Number	Marketed
Short Term Medical Policy	GN-71008-01 1/2008	03/06/09 to current

Recommendation No. 25:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-102, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to provide coverage, as required by Colorado insurance law, for self-inflicted injuries, suicide, and attempted suicide for covered persons that are insane.

Issue E22: Failure, in some instances, to allow coverage to continue for an insured based solely on that individual's membership in the uniformed services of the United States.

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

. . .

(16)(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 not refuse to provide coverage to an individual, *refuse to continue to cover an individual*, or limit the amount or extent of coverage available to an individual *solely based on that individual's membership in the uniformed services of the United States*. Nothing in this subsection (16) shall prohibit an insurer from excluding or limiting coverage for some other factor or preexisting condition. [Emphases added.]

(b) As used in this subsection (16):

(I) "Membership" means active duty, national guard, or reserve duty in the uniformed services of the United States, or retirement from such services.

(II) "Uniformed services of the United States" means the United States Army, United States Navy, United States Marine Corps, United States Air Force, United States Coast Guard, national oceanic and atmospheric administration commissioned officer corps, and the United States public health service commissioned corps.

HIC's Basic and Standard Plans and the small group plans reviewed are not in compliance with Colorado insurance law in that they reflect that coverage will terminate on the date an insured enters full-time military, naval or air service.

Page 43 of the Basic PPO Limited Mandate Plan,
Page 36 of the Basic Indemnity Limited Mandate Plan,
Page 42 of the Standard PPO Health Benefit Plan, and
Page 37 of the Standard Indemnity Health Benefit Plan reflect:

TERMINATION OF COVERAGE

When **We** receive notification of a change in eligibility status in advance of the effective date of the change, insurance will terminate on the actual date specified by the **Employer** and or **Employee** or at the end of that month, as selected by **Your Employer** on the Employer Group Application.

Otherwise, insurance will terminate on the earliest of the following:
…
- The date **We** are notified that **You** entered full-time military, naval or air service;

Page 72 of the HDHP plan,
Page 71 of the Humana HDHP 08 plan,

Page 73 of the Humana PPO 08 plan, and
Page 73 of the Humana Coverage First 08 plan reflect:

> **TERMINATION PROVISIONS**
>
> **Termination of insurance**
>
> The date of termination, as described in this "Termination Provisions" section, may be the actual date specified or the end of that month, as selected by *your employer* on the Employer Group Application.
>
> When *we* receive notification of a change in eligibility status in advance of the effective date of the change, insurance will terminate on the actual date specified by the *employer* and/or *employee* or at the end of that month, as selected by *your employer* on the Employer Group Application.
>
> Otherwise, insurance terminates on the earliest of the following:
>
> - The date *you* entered full-time military, naval or air service;

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Health Benefit Plan	CO-57315-07 E BC	06/01/09 to current
CO Basic Indemnity Limited Mandate Health Benefit Plan	CO-57315-07 BAS E LE	06/01/08 to current
Standard PPO Health Benefit Plan	CO-57315-07 STD LE	06/01/08 to current
Standard Indemnity Health Plan	CO-57315-07 E STD LE	06/01/06 to current
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current

Recommendation No. 26:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to provide such proof, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to indicate, as required by Colorado insurance law, that coverage will not terminate based solely on an individual's membership in the uniformed services of the United States.

Issue E23: Failure to reflect all required disclosures in short-term limited duration health insurance applications.

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

. . .

(21)(b) "Health benefit plan" does not include: … Solely with respect to the provisions of section 10-16-118 (1) (b) concerning creditable coverage for individual policies, the term excludes individual short-term limited duration health insurance policies issued after January 1, 1999. This means such policies do not have to recognize creditable coverage. For the purpose of this paragraph (b), "short-term limited duration health insurance policy" means a nonrenewable individual health benefit plan with a specified duration of not more than six months *that meets the following requirements*: [Emphasis added.]

(I) The short-term limited duration health insurance policy is issued only to individuals who have not had more than one such policy providing the same or similar nonrenewable coverage from any carrier within the past twelve months and so states in all marketing materials, application forms, and policy forms. *An applicant shall be deemed to be eligible for coverage if a short-term carrier includes in its application form the following: "Have you or any other person to be insured been covered under two or more nonrenewable short-term policies during the past twelve months? If "yes" then this policy cannot be issued. You must wait six months from the date of your last such policy to apply for a short-term policy*." [Emphasis added.]

(II) The short-term limited duration health insurance policy *contains the following disclosure in ten-point or larger bold-faced type* in all marketing materials, *application forms*, and policy forms: "*This policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within twelve months of the effective date of this policy will not be covered under this policy*." [Emphases added.]

HIC's short-term limited duration health insurance application is not in compliance with Colorado insurance law from the beginning of the exam period until it was corrected 5/1/09. The application did not reflect the following two (2) requirements:

(1) The required question for determining that the individual applying for coverage has not had more than one such policy providing the same or similar nonrenewable coverage from any carrier within the past twelve months.

(2) The required disclosure concerning "no portability of prior coverage."

Form Name	Form Number
Short-Term Medical Application	CO-71004 5/2008

Recommendation No. 27:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-102, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all short-term limited duration application forms to reflect complete information as required by Colorado insurance law.

Issue E24: Failure, in some instances, to reflect complete or correct benefits to be provided for child health supervision services.

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*. … [Emphasis added.]

(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 (Effective January 1, 2008), 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:

. . .

Attachment 1

Covered Preventive Services [1]	
All Children	Immunizations. Immunization deficient children are not bound by "recommended ages".
Age 0-12 months	*1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.* *6 well-child visits* [2] 1 PKU
Age 13-35 months	*3 well-child visits*
Age 3-6	*4 well-child visits*
Age 7-12	*4 well-child visits* [Emphases added.]

1: Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

2: "Well-child visit" means a visit to a primary care provider that includes the following elements; age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12, is based on the recommendations of the American Academy of Pediatrics.

Emergency Insurance Regulation 4-6-5 (Effective November 4, 2008 with benefits effective January 1, 2009), 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:

. . .

Attachment 1

Covered Preventive Services [1]	
All Children	Immunizations. Immunization deficient children are not bound by "recommended ages".
Age 0-12 months	*1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.* *6 well-child visits* [2] 1 PKU
Age 13-35 months	*3 well-child visits*
Age 3-6	*4 well-child visits*
Age 7-12	*4 well-child visits* [Emphases added.]

1: Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

2: "Well-child visit" means a visit to a primary care provider that includes the following elements; age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12, is based on the recommendations of the American Academy of Pediatrics.

Colorado Insurance Regulation 4-6-5 (Effective February 1, 2009), 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:

. . .

Attachment 1

Covered Preventive Services [1]	
All Children	Immunizations. Immunization deficient children are not bound by "recommended ages".
Age 0-12 months	*1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.* *6 well-child visits* [2] 1 PKU
Age 13-35 months	*3 well-child visits*
Age 3-6	*4 well-child visits*
Age 7-12	*4 well-child visits* [Emphases added.]

1: Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

2: "Well-child visit" means a visit to a primary care provider that includes the following elements; age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12, is based on the recommendations of the American Academy of Pediatrics.

Colorado Division of Insurance, Bulletin No. B-4.24, Child Health Immunizations, states in part:

I. Background and Purpose

The purpose of this bulletin is to provide health carriers offering individual, small group or large group health benefit plans information regarding the requirement to provide child health supervision services for children up to the age of thirteen in accordance with Section 10-16-104(11), C.R.S. Included in that requirement is coverage by the basic and standard health benefit plans pursuant to Section 10-16-105(7.2), C.R.S., and Colorado Division of Insurance Regulation 4-6-5.

Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.

II. Applicability and Scope

This bulletin is intended for all regulated entities that issue health benefit plans as defined in Section 10-16-102(21), C.R.S.

HIC's small group plans reviewed are not in compliance with Colorado insurance law in that the covered expenses reflected for Child Health Supervision Services are not complete or correct in the following ways:

(1) Nothing is reflected to indicate that one (1) newborn home visit <u>during the first week of life</u> is to be covered if the newborn is released from the hospital less than forty-eight (48) after delivery.

(2) Coverage for 5 well child visits is reflected for ages 0-12 months instead of the correct six (6) well child visits.

(3) Coverage for two (2) well child visits is reflected for ages 13-35 months instead of the correct three (3) well child visits.

(4) Coverage for three (3) well child visits is reflected for ages 3-6 years instead of the correct four (4) well child visits.

(5) Coverage for three (3) well child visits is reflected for ages 7-12 years instead of the correct four (4) well child visits.

HIC's Standard Indemnity plan is not in compliance with Colorado insurance law in that it reflects the same incorrect number of well child visits for the four (4) age categories as the small group plans.

HIC's individual policies reviewed are not in compliance with Colorado insurance law in that the coverage reflected for child health supervision services is not complete in the following ways:

(1) Nothing is reflected to indicate that Immunization deficient children are not bound by "recommended ages".

(2) Nothing is reflected to indicate that PKU testing is to be covered.

(3) There is no definition of a "well-child visit".

(4) Nothing is reflected concerning the one (1) newborn home visit to be covered during the first week of life if a newborn is released from the hospital less than 48 hours after delivery.

Page 38 of the HDHP small group plan,
Page 37 of the Humana HDHP 08 small group plan, and
Page 39 of the Humana PPO 08 and the Humana Coverage First 08 small group plans reflect:

COVERED EXPENSES

Benefits are provided for Child Health Supervision services for covered *dependents* up to age 13 based on the following schedule:

- Immunizations (covered immunizations are those recommended by the American Academy of Pediatrics). Immunization deficient children are not bound by the "recommended ages" of the American Academy of Pediatrics.

- Chicken pox vaccination for those who have not had the chicken pox.

- 5 well child visits and 1 PKU from 0-12 months

- 2 well child visits from 13-35 months

- 3 well child visits from 3-6 years
- 3 well child visits from 7-12 years

Benefits are limited to the above specified number of visits for each age group and are not subject to the deductible, or dollar limit provisions.

Page 16 of the Standard Indemnity plan reflects:

Ages 0-12 months	1 newborn home visit during the first week of life if the newborn is released from the **Hospital** within 48 hours after delivery. *5* ***well child visits*** 1 PKU
Ages 13-35 months	*2* ***Well Child Visits***
Ages 3-6	*3* ***Well Child Visits***
Ages 7-12	*3* ***Well Child Visits*** [Emphases added.]

Form Name	Form Number	Marketed
HDHP Plan	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
Standard Indemnity	CO-57315-07 E SIN 1/2006	06/01/06 to current
Short Term Medical STM 100/75	GN-71008-01 1/2008	3/6/09 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 28:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect complete and correct covered expenses for child health supervision services as required by Colorado insurance law.

Issue E25: Failure, in some instances, to reflect complete or correct benefits to be provided for prostate cancer screening.

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

…

(10) Prostate cancer screening.

(a) 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 offered to residents of this state, *shall provide coverage for annual screening for the early detection of prostate cancer* in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles. *Such coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. Such benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy*. This coverage shall be provided according to the following guidelines: [Emphasis added.]

(I) The screening shall be performed by a qualified medical professional, including without limitation a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or physician assistant.

(II) The screening shall consist, at a minimum, of the following tests:

A. A prostate-specific antigen ("PSA") blood test;

B. Digital rectal examination.

HIC's small group plans reviewed are not in compliance with Colorado insurance law in that the benefits expressed for prostate cancer screenings are incorrect and incomplete in the following ways:

<u>Incorrect</u>

- Colorado insurance law has a set amount which is used to calculate the benefit amount that will be paid. This amount of $65.00 is not derived from the most current Denver medical care services component of the CPI-U per screening and is not routinely re-calculated on an annual basis.

<u>Incomplete</u>

- There is nothing reflected to indicate that this benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy in the HDHP and the Humana Coverage First 08 plans.

- Although it is stated that expenses include charges as recommended by the United States Preventive Services Task Force, nothing specific is reflected to indicate that the coverage provided is for annual screenings.

HIC's Standard Indemnity Health Benefit Plan is not in compliance with Colorado insurance law in that the benefit expressed for prostate cancer screenings is incorrect in the following way:

> Colorado insurance law has a set amount which is used to calculate the benefit amount that will be paid. The lesser of this amount of sixty-five dollars or the actual charge for the screening is to be paid.

Four (4) of HIC's individual policies are not in compliance with Colorado insurance law in that the benefits expressed for prostate cancer screenings are incorrect. Colorado insurance law has a set amount for both in and out-of-network which is to be used to calculate the benefit amount that will be paid. The benefit is not to be paid as a percentage of covered expenses, but as the lesser of sixty-five dollars per screening or the actual charge for such screening.

Small Group Plans

Page 16 of the HDHP plan reflects:

> **SCHEDULE OF BENEFITS**
>
> **Preventive mammogram and prostate specific antigen (PSA) test**
>
> *Covered expense* will be the lesser of:
>
> - The most current Denver medical care services component of the CPI-U per screening; or
>
> - The actual charge of the screening.

Page 37 of the HDHP plan,
Page 36 of the Humana HDHP 08 plan,
Page 38 of the Humana PPO 08 plan and
Page 38 of the Humana Coverage First plan reflect:

> **COVERED EXPENSES**
>
> **Preventive screenings and immunizations**
>
> *Covered expenses* include charges incurred by *you* for the following *preventive services* as recommended by the United States Preventive Services Task Force:
>
> A prostate specific antigen (PSA) test for a male *covered person* 40 years of age or older. The screening must be performed by a health care practitioner. The screening must consist of a:
>
> - PSA blood test; and
> - Digital rectal exam.

Page 17 of the Humana HDHP 08 plan reflects:

SCHEDULE OF BENEFITS

Routine prostate specific antigen (PSA) test

(Is not limited by the *preventive services* maximum benefit per *year)*

Covered expense will be the lesser of:

- The most current Denver medical care services component of the CPI-U per screening; or
- The actual charge of the screening.

Page 17 of the Humana PPO 08 plan and
Page 17 of the Humana Coverage First plan reflect:

SCHEDULE OF BENEFITS

Prostate specific antigen (PSA) test

Covered expense will be the lesser of:

- The most current Denver medical care services component of the CPI-U per screening; or
- The actual charge of the screening.

Page 15 of the Standard Indemnity Health Benefit Plan reflects:

PREVENTIVE CARE

Covered Expenses for Preventive Care for **Covered Persons** ages 12 and younger and for prostate screenings and mammograms will be payable at 80%.

Individual Policies

Page 10 of the IMM OV Copay Policy,
Page 10 of the Portrait IMM (RX deductible of $500 and no SAB) Policy,
Page 10 of the Portrait IMM (No RX deductible) Policy, and
Page 10 of the Portrait IMM ($1,000 SAB) Policy reflect:

SCHEDULE

14. Preventive Care

C. Mammograms, PSA testing, Digital Rectal Exams, and Child Health Supervision Services to age 13

Network Provider: *You* pay 20% *coinsurance*, *we* pay 80% of *covered expenses*

Non-Network Provider: *You* pay 40% *coinsurance*, *we* pay 60% of *covered expenses*

Page 10 of the Monogram, IMM 100Rx, (No Supplemental Accident Benefit) Policy, and
Page 9 of the Monogram, IMM 100 Rx, (SAB of $1,000) Policy reflect:

Non-Network Provider: *You* pay 25% *coinsurance*, we pay 75% of *covered expenses*

Page 11 of the Autograph, HSAQ 100 Rx, (Single Deductible of $2,500 and Lifetime Max of $5,000,000),
Page 10 of the Autograph, HSAQ 100, (Single Deductible of $5,200 and Lifetime Max of $2,000,000 and
Page 9 of the Autograph, HSAQ 100 Rx, (Single Deductible of $5,000 and Lifetime Max of $5,000,000) reflect:

Non-Network Provider: *You* pay 30% *coinsurance*, *we* pay 70% of *covered expenses*

Form Name	Form Number	Marketed
HDHP Plan	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
Standard Indemnity Plan	CO-57315-07 E SIN 1/2006	06/01/06 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM	CO-70129 SCH 8/2002	4/21/07 to current

(No RX deductible) Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 29:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to show provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect complete and correct covered expenses for prostate cancer screenings as required by Colorado insurance law.

Issue E26: Failure, in some instances, to reflect the mandated coverage for cervical cancer vaccinations.

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.]

HIC's small group plans reviewed and its Standard Indemnity plan are not in compliance with Colorado insurance law in that the mandated benefit for cervical cancer vaccination for all females for whom a vaccination is recommended, is not reflected.

Pages 15, 16 and 17 of the Standard Indemnity plan reflect the Covered Preventive Services in Attachment 1 of Regulation 4-6-5; however, a cervical cancer vaccination for females is not reflected.

Page 37 of the HDHP Plan,
Page 36 of the Humana HDHP 08 plan,
Page 38 of the Humana PPO 08 plan, and
Page 38 of the Coverage First 08 plan reflect:

COVERED EXPENSES

Preventive services

Preventive screenings and immunizations

Covered expenses include charges incurred by *you* for the following *preventive services* as recommended by the United States Preventive Services Task Force:

- Laboratory, radiology and/or endoscopic services to detect or prevent *sickness.*

- A baseline mammogram for a female *covered person* between the ages of 35 and 40 and an annual mammogram for a female *covered person* 40 years of age or older.

- Routine pap smear.

- A prostate specific antigen (PSA) test for a male *covered person* 40 years of age or older. The screening must be performed by a health care practitioner. The screening must consist of a:

  - PSA blood test; and
  - Digital rectal exam.

- Routine immunizations for *covered persons* under the age of 18. TB tine tests and allergy desensitization injections are not considered routine immunizations.

- Immunizations against influenza and pneumonia.

The Humana HDHP 08 plan, the PPO 08 plan and the Coverage First 08 plan, reflect the following additional wording:

- Routine hearing screening.

- Routine vision screening (not including refractions).

Form Name	Form Number	Marketed
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
Standard Indemnity	CO-57315-07 E SIN 1/2006	06/01/06 to current

Recommendation No. 30:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect coverage for cervical cancer vaccinations as required by Colorado insurance law.

Issue E27: Failure, in some instances, to reflect the correct upper age limit for medically necessary therapy to be provided for congenital defects and birth abnormalities.

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:

. . .

(II) "Early intervention services" means services as defined by the division in accordance with part C that are authorized through an eligible child's IFSP but that exclude nonemergency medical transportation; respite care; service coordination, as defined in 34 CFR 303.12 (d) (11); and assistive technology, unless assistive technology is covered under the applicable insurance policy or service or indemnity contract as durable medical equipment.

(III) "*Eligible child*" means an *infant or toddler, from birth through two years of age,* who is an eligible dependent and who, as defined by the department pursuant to section 27-10.5-702 (9), C.R.S., *has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to section 27-10.5-102 (11) (c), C.R.S.*

(IV) *"Individualized family service plan" or "IFSP*" means a written plan developed pursuant to 20 U.S.C. sec. 1436 and 34 CFR 303.340 that authorizes early intervention services to an eligible child and the child's family. An IFSP shall serve as the individualized plan, pursuant to section 27-10.5-102 (20) (c), C.R.S., for an eligible child from birth through two years of age.

. . .

(VI) "*Qualified early intervention service provider*" or "qualified provider" *means a person or agency,* as defined by the division in accordance with part C, *who provides early intervention services and is listed on the registry of early intervention service providers pursuant to section 27-10.5-708 (1) (a), C.R.S.*

(b) (I) *All* individual and *group sickness and accident insurance policies or contracts* issued or renewed by an entity subject to part 2 of this article *on or after January 1, 2008,* and all service or indemnity contracts issued or renewed 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.

(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, or by such additional amount to be equal to the increase by the general assembly to the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that increase is more than the consumer price index increase.

. . .

(IV) The limit on the amount of coverage for early intervention services specified in subparagraph (II) of this paragraph (b) shall not apply to:

. . .

(B) Services provided to a child who is no participating in part C and services that are not provided pursuant to an IFSP. However, such services shall be covered at the level specified in paragraph (b) of subsection (1.7) of this section.

. . .

(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.]

HIC's small group plans reviewed are not in compliance with Colorado insurance law in that the mandated coverage reflected to be provided for therapies for congenital defects and birth abnormalities is incorrect. The benefit is to be provided from the child's third birthday to the child's sixth birthday.

The Covered Expenses section of the plan indicates medically necessary physical, occupational, and speech therapy for the care of congenital defects and birth abnormalities is to be provided for children up to five (5) years of age.

Pages 25 and 26 of the HDHP and Humana HDHP 08 plans reflect:

> **Physical medicine and rehabilitative services for the treatment of congenital defects and birth abnormalities from birth through age 4**
>
> **Speech therapy**
>
> Limited to a maximum of 20 visits per *year* which accumulates towards but not limited by the physical medicine and rehabilitative services for all other conditions.
>
> **Physical therapy**
>
> Limited to a maximum of 20 visits per *year* which accumulates towards but not limited by the physical medicine and rehabilitative services for all other conditions.
>
> **Occupational therapy**
>
> Limited to a maximum of 20 visits per *year* which accumulates towards but not limited by the physical medicine and rehabilitative services for all other conditions.

Pages 27 and 28 of the Humana PPO 08 plan and
Pages 26 and 27 of the Humana Coverage First 08 plan reflect:

> **Physical medicine and rehabilitative services for the treatment of congenital defects and birth abnormalities from birth through age 4**
>
> **Speech therapy**
>
> Limited to a maximum of 25 visits per *year* which accumulates towards but not limited by the physical medicine and rehabilitative services for all other conditions.
>
> **Physical therapy**
>
> Limited to a maximum of 25 visits per *year* which accumulates towards but not limited by the physical medicine and rehabilitative services for all other conditions.
>
> **Occupational therapy**
>
> Limited to a maximum of 25 visits per *year* which accumulates towards but not limited by the physical medicine and rehabilitative services for all other conditions.

Page 47 of the HDHP plan,
Page 46 of the Humana HDHP 08 plan, and
Page 48 of the Humana PPO 08 and the Humana Coverage First 08 plans reflect:

> *Covered expenses* include *medically necessary* physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered dependent children up to five years of age without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

Form Name	Form Number	Marketed
HDHP Plan	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current

Recommendation No. 31:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect the correct age limits for which therapies for congenital defects and birth abnormalities are to be provided for a covered child as required by Colorado insurance law.

Issue E28: Failure, in some instances, to reflect that coverage is to be provided for replacement of prosthetic devices unless necessitated by misuse or loss.

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

. . .

(14) Prosthetic devices.

(a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42, U.S.C. secs. 1395k, 13951, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100, as applicable to this subsection (14).

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

. . .

(e) Repairs *and replacements of prosthetic devices are also covered*, subject to copayments and deductibles, unless necessitated by misuse or loss. [Emphasis added.]

HIC's small group plans were not in compliance with Colorado insurance law in that the description of coverage to be provided for prosthetic devices was more limiting than allowed by Colorado insurance law during the period under examination. Coverage is to be provided for "replacement" of prosthetic devices, as well as repair, unless necessitated by misuse or loss and HIC has indicated the certificate language was not corrected to reflect this until July 23, 2009.

Page 48 of the HDHP small group plan,
Page 47 of the Humana HDHP 08 small group plan,
Page 49 of the Humana PPO 08 small group plan, and
Page 49 of the Humana Coverage First 08 small group plan reflect:

COVERED EXPENSES

Additional covered expenses

We will pay benefits for *covered expenses* incurred by *you* based upon the location of the services and the type of provider for:

- Initial prosthetic devices or supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye. *Covered expense* includes repair of the prosthetic device UNLESS covered by the manufacturer or damage is due to misuse.

Form Name	Form Number	Marketed
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current

Recommendation No. 32:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect coverage for replacement of prosthetic devices as required by Colorado insurance law.

Issue E29: Failure, in some instances, to reflect correct or complete grievance and appeal procedures.

Section 10-16-113, Procedure for denial of benefits - internal review – rules, states in part:

(1)(a) A health coverage plan shall not make a determination, in whole or in part, that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.

. . .

(3)(a)(II)(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, *the carrier shall furnish the covered person and the covered person's representative with either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the covered person and the covered person's designated representative upon request*; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, *the carrier shall furnish the covered person and the covered person's designated representative with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon request.* [Emphasis added.]

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 6 Standard Utilization Review

. . .

C. Retrospective review determinations.

1. For retrospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, *but in no event later than thirty (30) days after the date of receiving the benefit request*. If the determination is an adverse determination, the health

carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection E. [Emphasis added.]

. . .

Section 10 First Level Review

J. A first level review decision involving an adverse determination issued pursuant to subsection G. shall include, in addition to the requirements of subsection I.:

1. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;

2. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in subsection F.2., to the covered person's benefit request;

3. If the reviewers relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

4. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and

5. If applicable, instructions for requesting:

   a. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in paragraph 3. of this subsection; and

   b. The written statement of the scientific or clinical rationale for the determination, as provided in paragraph 4. of this subsection.

6. A description of the process to obtain a voluntary second level review, including:

   a. The written procedures governing the voluntary second level review, including any required time frames for the review;

   b. The right of the covered person to:

(1) Request the opportunity to appear in person before a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, who have appropriate expertise, who were not previously involved in the appeal, and who do not have a direct financial interest in the outcome of the review;

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

(3) Present written comments, documents, records and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting;

(a) A copy of the materials the covered person plans to present or have presented on his or her behalf at the review should be provided to the health carrier at least five (5) days prior to the date of the review meeting.

(b) Any new material developed after the five-day deadline shall be provided to the carrier when practicable;

(4) Present the covered person's case to the reviewer or review panel;

(5) If applicable, ask questions of the reviewer or review panel; and

(6) Be assisted or represented by an individual of the covered person's choice, including counsel, advocates, and health care professionals;

c. A statement that the carrier will provide the covered person, upon request, sufficient information relating to the voluntary second level review to enable the covered person to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process for selecting the decision maker, and the impartiality of the decision maker.

d. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to Colorado Insurance Regulation 4-2-21 if the covered person chooses not to file

for a voluntary second level review of the first level review decision involving an adverse determination.

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 6 Request for External Review

. . .

D. All requests for external review shall include a signed consent, authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review.

. . .

Section 8 Standard External Review

. . .

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 carrier's 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 conditions applicable to benefits under the health coverage plan. [Emphasis added.]

HIC's small group plans are not in compliance with Colorado insurance law in that the grievance and appeal procedures and pertinent "Notice" pages reflect incorrect and incomplete material in the following ways:

<u>Incorrect</u>

(1) The time periods reflected for decisions on appeal of post-service claims is incorrect. A decision for retrospective review determinations is to be made no later than thirty (30) days after the date of receiving the benefit request, not sixty (60) days.

Incomplete

(1) The rights of a covered person involving an independent external review does not include the right to receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits. There is a statement as follows: "Detailed appeal procedures are available upon request from *us*." A copy of these "detailed appeal procedures" was requested by the examiners and when provided they consisted of five (5) pages titled "Disclosure Process for Relevant Documentation Policy and Procedure" dealing with an overview, examples of relevant documents and the process for providing the documents necessary. This was for any appeal, however an insured should not have to request additional information from HIC to find out that they have a right to receive, free of charge, copies of all documents, records and other information relevant to the covered person's request for benefits.

(2) The requirements for submitting a request for an independent external review do not reflect that all requests shall include a signed consent authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review.

(3) There is notification that a request for a second level review may be submitted if the covered person is unable to resolve their concerns through the first level appeal process, but there is no other information concerning the process, rights of the covered person or time frames within which requests and determinations are to be made.

(4) The timelines indicated in the plan for a standard external review do not reflect:

(a) That for concurrent and prospective reviews, the carrier shall approve the coverage within one (1) working day,

(b) That for retrospective reviews, the carrier shall approve the coverage within five (5) working days or,

(c) That 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.

Page 7 of the "Notice Pages" for Humana's HDHP small group plan, the Humana HDHP 08 small group plan, the Humana PPO 08 small group plan, and the Humana Coverage First 08 small group plan reflect:

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- **Post-service claims** – Within a reasonable period but no later than *60 days* after Humana receives the appeal request. [Emphasis added.]

Page 93 of the HDHP small group plan,
Page 92 of the Humana HDHP 08 small group plan,
Page 94 of the Humana PPO 08 small group plan, and

Page 94 of the Humana Coverage First 08 small group plan reflect:

GRIEVANCE AND APPEAL PROCEDURES

Independent external review

You must complete the first level appeal process prior to requesting an independent external review. If *you* are not satisfied with the outcome of *your* appeal, *you* or *your designated representative* may request a standard or expedited independent external review. The request must:

- Be submitted to *us* in writing within sixty (60) calendar days after *you* receive *our* final *adverse determination*; and
- Include a completed "Request for Independent External Review of Carrier's Final Adverse Determination" form.

You or *your designated representative* may contact *us* at the following:

HUMANA INSURANCE COMPANY
GRIEVANCE AND APPEALS OFFICE
P.O. BOX 14618
LEXINGTON, KY 40512-4618
(800) 558-4444

Page 92 of the HDHP small group plan,
Page 91 of the Humana HDHP 08 small group plan,
Page 93 of the Humana PPO 08 small group plan, and
Page 93 of the Humana Coverage First 08 small group plan reflect:

Second level appeal

If *we* are unable to resolve *your concerns through the first level appeal process*, you or *your designated representative* are entitled to submit a written *grievance*, requesting a second level review.

You or *your designated representative* may contact *us* at the following:

HUMANA INSURANCE COMPANY
GRIEVANCE AND APPEALS OFFICE
P.O. BOX 14618
LEXINGTON, KY 40512-4618

Form Name	Form Number	Marketed
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current

Recommendation No. 33:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S., and Colorado Insurance Regulations 4-2-17 and 4-2-21, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect complete and correct grievance and appeal procedures as required by Colorado insurance law.

Issue E30: Failure, in some instances, to clearly reflect the mandated coverage for complications of pregnancy and childbirth.

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

(2) Complications of pregnancy and childbirth.

(a) Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of this article and any individual or group service or indemnity contract issued by an entity subject to part 3 of this article *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 or contract*. Any sickness and accident insurance policy providing indemnity for disability due to accident shall provide coverage for an accident which occurs during the course of pregnancy or childbirth in the same manner as any other similar accident is covered under the policy. [Emphasis added.]

(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" for use in Accident and Health Insurance Policies, promulgated under the authority of §§ 10-1-109, 10-16-109 and 10-3-1110, C.R.S., states in part:

…

Section 4. Definitions

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

…

(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. [Emphasis added.]

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.]

HIC's small group plans reviewed are not in compliance with Colorado insurance law in that the certificate language concerning the mandated coverage for complications of pregnancy and childbirth is

not clearly reflected. In addition, there is no definition of the conditions that qualify as a complication of pregnancy.

For a period of time during the examination period, nine (9) of HIC's eleven (11) individual policies being reviewed were not in compliance with Colorado insurance law in that the definition of what constitutes "complications of pregnancy" was more limiting than allowed by Colorado insurance law. The definition excluded "cesarean section" until May 28, 2008 at which time HIC implemented revised policy language to reflect that a non-elective cesarean is considered a complication of pregnancy that is to be covered.

Form Name	Form Number	Marketed
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000))	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 34:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-6, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect clearly the mandated coverage for complications of pregnancy.

Issue E31: Failure to reflect correct coverage to be provided for newborns in a maternity rider.

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.* …

(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 (effective January 1, 2008), 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:

CONCERNING SMALL EMPLOYER GROUP HEALTH BENEFIT PLANS AND THE BASIC AND STANDARD HEALTH BENEFIT PLANS

Attachment 1

Covered Preventive Services [1]	
Age 0-12 months	*1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.* [Emphasis added.] 6 well-child visits [2] 1 PKU

1: Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

2:"Well-child visit" means a visit to a primary care provider that includes the following elements; age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children,

this also includes safety and health education counseling. The schedule of these visits, through age 12 is based on the recommendations of the American Academy of Pediatrics.

Emergency Insurance Regulation 4-6-5 (effective November 4, 2008 with benefits effective January 1, 2009), 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:

CONCERNING SMALL EMPLOYER GROUP HEALTH BENEFIT PLANS AND THE BASIC AND STANDARD HEALTH BENEFIT PLANS

Attachment 1

Covered Preventive Services [1]	
Age 0-12 months	*1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.* [Emphasis added.] 6 well-child visits [2] 1 PKU

1: Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

2:"Well-child visit" means a visit to a primary care provider that includes the following elements; age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12 is based on the recommendations of the American Academy of Pediatrics.

Colorado Insurance Regulation 4-6-5 (effective February 1, 2009), 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:

CONCERNING SMALL EMPLOYER GROUP HEALTH BENEFIT PLANS AND THE BASIC AND STANDARD HEALTH BENEFIT PLANS

Attachment 1

Covered Preventive Services [1]	
Age 0-12 months	*1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.* [Emphasis added.] 6 well-child visits [2] 1 PKU

1: Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

2:"Well-child visit" means a visit to a primary care provider that includes the following elements; age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance

and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12 is based on the recommendations of the American Academy of Pediatrics.

HIC's Maternity Rider, a one (1) page, optional rider used with one of the individual policies reviewed, is not in compliance with Colorado insurance law in that if a newborn is released from the hospital less than forty-eight (48) hours after delivery, one (1) newborn home visit is to be covered during the first week of life. The rider reflects that this benefit is to be provided in the first forty-eight (48) hours after discharge and does not reflect the conditions under which the benefit would be provided.

Additionally, HIC's Maternity Rider is not in compliance with Colorado insurance law in reflecting a "Waiting Period" of one (1) year for pregnancy and newborn, well-baby coverage. Newborns are automatically covered from the moment of birth for 31 days.

The Maternity Rider reflects:

Pregnancy and newborn well-baby services

Covered expense includes:

- *Inpatient services* provided to the mother for:

  A minimum of 48 hours, following a vaginal delivery; or

  A minimum of 96 hours, following a cesarean section;

Unless the following applies:

A post-discharge office visit to the physician *or in-home nurse visit is provided in the first 48 hours after discharge.* [Emphasis added.]

MATERNITY RIDER

This benefit rider is attached to and made a part of *your policy*. Except as modified below, all *policy* terms, conditions and limitations apply.

Pregnancy and newborn well-baby services

<u>Refer to the "Schedule page" for any applicable waiting period.</u>

Page 12 of the IMM OV Copay Policy, one of the individual policies being reviewed had the Maternity Rider attached and it reflected:

SCHEDULE

Maternity rider

- Waiting period for pregnancy and newborn well-baby coverage……1 year

Form Name	Form Number
Maternity Rider	CO-70129 MAT 8/2002

Recommendation No. 35:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-6-5, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect correctly the coverage to be provided for newborns as required by Colorado insurance law.

Issue E32: Failure, in some instances, to reflect correct out-patient benefits for mental illness.

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

. . .

(5) Mental illness.

Every small group policy providing hospitalization or medical benefits by an entity subject to the provisions of part 2 or 3 of this article shall provide benefits for conditions arising from mental illness at least equal to the following:

. . .

(b)(I) In the case of major medical coverage, *benefits shall cover outpatient services* furnished by a comprehensive health care service corporation, a hospital, or a community mental health center or other mental health clinics approved by the department of human services to furnish mental health services; or furnished by a registered professional nurse within the scope of his or her license; or furnished by a licensed clinical social worker within the scope of his or her license; or furnished by or under the supervision of a licensed physician or licensed psychologist acting in compliance with part 3 of article 43 of title 12, C.R.S. Except as provided in subparagraph (II) of this paragraph (b), the services provided under this paragraph (b) shall be under the direct supervision of a physician or a licensed psychologist acting in compliance with part 3 of article 43 of title 12, C.R.S. The patient records shall show that the attending physician or licensed psychologist acting in compliance with part 3 of article 43 of title 12, C.R.S., either saw the patient or had a written summary of consultations or a personal consultation with the therapist at least once every ninety days. [Emphasis added.]

(c) An entity subject to the provisions of part 2 or 3 of this article may establish a copayment or coinsurance requirement for mental illness, which may or may not differ from the copayment or coinsurance requirement established for any other condition or illness; except that copayment or coinsurance requirements for mental illness shall not exceed a fifty percent copayment or coinsurance requirement. Such entity may establish a deductible amount for mental illness, but such deductible amount shall not differ from the deductible amount for any other condition or illness. In addition, *such entity may limit the aggregate benefits payable under paragraph (b) of this subsection (5) to an amount of not less than one thousand dollars in any one twelve-month benefit period or not less than twenty visits per year.* [Emphasis added.]

HIC's Humana HDHP 08, Humana PPO 08, and Humana Coverage First 08 small group plans were not in compliance with Colorado insurance law in that if the choice is to provide mental illness outpatient service benefits of annual "visits" versus "an amount of not less than one thousand dollars," the visits cannot be limited to less than twenty (20) visits per year. HIC indicated in its response to the issue that the language was corrected sometime after 11/02/08 and before 6/01/09.

Page 30 of the Humana HDHP 08 small group plan,
Page 32 of the Humana PPO 08 small group plan, and
Page 31 of the Humana Coverage First 08 small group plan reflect:

> **SCHEDULE OF BENEFITS – BEHAVIORAL HEALTH**
>
> **Outpatient care and office therapy**
>
> *Outpatient* care and office therapy individual and group sessions for non-*biologically based mental illness* are limited to a maximum of 15 visits per *year*.

Form Name	Form Number	Marketed
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current

Recommendation No. 36:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect correctly the coverage to be provided for outpatient services for conditions arising from mental illness as required by Colorado insurance law.

Issue E33: Failure to disclose counties of the state where there are no participating providers and to disclose in bold-faced type the disclosure concerning balance billing.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

. . .

(2)(d) The carrier *shall provide, in conspicuous, bold-faced type, an understandable disclosure in policy contract materials*, certificates of coverage for a policyholder, and marketing materials about the following: [Emphasis added.]

(I) *Specific counties of the state where there are no participating providers*; [Emphasis added.]

(II) *The circumstances under which the covered person may be balanced billed by nonparticipating providers*; [Emphasis added.]

HIC's individual policies examined are not in compliance with Colorado insurance law in that there is no disclosure in them of the specific counties of the state where there are no participating providers and the disclosure concerning the circumstances under which a covered person is alerted that they may be balance billed is not reflected in the required ***bold-faced type.***

Page 12 of the Short Term Medical Policy,
Page 15 of the IMM-OV Copay Policy,
Pages 15 of the AMP Policy,
Page 15 of a Monogram, IMM 100Rx Policy,
(No Supplemental Accident Benefit)
Page 15 of a Monogram, IMM 100Rx Policy,
(SAB of $1,000)
Page 14 of an Autograph, HSAQ 100 Rx Policy,
(Single Deductible of $2,500 and Lifetime Max of $5,000,000))
Page 14 of an Autograph, HSAQ 100 Policy,
(Single Deductible of $5,200 and Lifetime Max of $2,000,000)
Page 14 of an Autograph, HSAQ 100 Rx Policy,
(Single Deductible of $5,000 and Lifetime Max of $5,000,000)
Page 15 of a Portrait IMM Policy,
(RX deductible of $500 and no SAB)
Page 15 of a Portrait IMM Policy
(No RX deductible), and
Page 15 of a Portrait Policy reflect:
(RX deductible of $500 and no SAB)

HOW WE PAY BENEFITS

Why are benefits paid differently for different providers?

. . .

If a *covered person* uses a *non-network provider*, the *covered person* will incur higher *coinsurance* costs. Additionally, *non-network providers* may balance bill you or the *covered person* for charges in excess of the maximum *allowable fee*. These additional charges will not apply toward the *coinsurance*, the *out-of-pocket limit* or the *deductible.*

Form Name	Form Number	Marketed
Short Term Medical-STM 100/75	GN-71008-01 1/2008	3/6/09 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 37:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect required disclosures concerning "counties with no participating providers" and "balance billing", as required by Colorado insurance law.

Issue E34: Failure, in some instances, to reflect the correct provisions under which coverage is to be provided for newborns.

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*. [Emphasis added.]

…

(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.]

Bulletin No. B-4.6, Mandatory Newborn Coverage and Premiums, states in part:

I. Background and Purpose

The purpose of this bulletin is to provide clarification regarding newborn coverage requirements and the collection of required premium as required in the Newborn Act, § 10-16-104(1), C.R.S. The Division of Insurance recognizes that the business of insurance has changed significantly since the Newborn Act was passed in 1975. The Act was initially intended to require coverage for newborn dependent children from the date of birth, prohibiting carriers from applying waiting periods before coverage could be effective or from applying pre-existing condition limitations for newborns.

The prevalence of managed care in the marketplace today, as well as other local and federal changes, including mandatory coverage of well child care and limits on pre-existing exclusions makes the interpretation of the Act more complex. After reviewing concerns raised by the industry, the Division has reviewed both the intent of the law, as well as proper application, in the current health insurance environment.

Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.

…

III. Division Position

It is the responsibility of the carrier to provide health coverage for newborn dependent children from the date of birth. In order for coverage to extend

> beyond the first thirty-one days, a carrier may require notification and payment of the required premiums within thirty-one days of the newborn dependent child's birth. [Emphasis added.]
>
> A. Coverage during the first thirty-one days.
>
> *Coverage must be provided automatically upon birth, continuing through the thirty-first day, without requiring notification or payment of premium*. Such coverage shall be provided for the first thirty-one days of life and shall include all coverage available under the policy, including coverage for well-baby services as mandated in § 10-16-104 (11), C.R.S. [Emphasis added.]

HIC's small group plans are not in compliance with Colorado insurance law in that they reflect that premium is due for any period of newborn dependent coverage whether the newborn dependent is enrolled or not. Colorado insurance law mandates coverage from the moment of birth for the first thirty-one (31) days and if the newborn is never enrolled in the plan, no premium can be charged for these thirty-one (31) days.

Furthermore, HIC's small group plans are not in compliance with Colorado insurance law in that an incorrect requirement is reflected for the automatic coverage to be provided for the first thirty-one (31) days of a newborn's life. This coverage is to be provided without an employee having to notify HIC of the birth.

Ten (10) of HIC's individual policies are not in compliance with Colorado insurance law in that an incorrect requirement is reflected for the automatic coverage to be provided for the first thirty-one (31) days of a newborn's life. This coverage is to be provided without the covered person or covered person's agent or health care practitioner having to notify HIC of the birth.

<u>Small Group Plans</u>

Page 68 of the HDHP plan,
Page 67 of the Humana HDHP 08 plan,
Page 69 of the Humana PPO 08 plan, and
Page 69 of the Humana Coverage First 08 plan reflect:

> **ELIGIBILITY AND EFFECTIVE DATES**
>
> **Newborn dependent effective date**
>
> - If *we* receive enrollment on, prior to, or within 31 days of the newborn's date of birth, *dependent* coverage is effective on the newborn's date of birth.
>
> - If *we* receive enrollment more than 31 days after the newborn's date of birth, the newborn is considered a *late applicant.* The newborn's *effective date* of coverage will be the first of the month following receipt of the enrollment.
>
> - If the *employee* already has *dependent* child coverage, and enrollment is <u>not</u> required, *dependent* coverage is effective on the newborn's date of birth. However, the *employee* must notify *us* of the birth.

NOTE: Premium is due for any period of newborn *dependent* coverage whether the newborn *dependent* is enrolled or not, unless specifically not allowed by applicable law.

Page 68 of the HDHP plan,
Page 67 of the Humana HDHP 08 plan,
Page 69 of the Humana PPO 08 plan, and
Page 69 of the Humana Coverage First 08 plan reflect:

ELIGIBILITY AND EFFECTIVE DATES

Newborn dependent effective date

- If *we* receive enrollment on, prior to, or within 31 days of the newborn's date of birth, *dependent* coverage is effective on the newborn's date of birth.

- If *we* receive enrollment more than 31 days after the newborn's date of birth, the newborn is considered a *late applicant.* The newborn's *effective date* of coverage will be the first of the month following receipt of the enrollment.

- If the *employee* already has *dependent* child coverage, and enrollment is <u>not</u> required, *dependent* coverage is effective on the newborn's date of birth. However, the *employee* must notify *us* of the birth.

  NOTE: Premium is due for any period of newborn *dependent* coverage whether the newborn *dependent* is enrolled or not, unless specifically not allowed by applicable law.

<u>Individual Policies</u>

Page 50 of the IMM-OV Copay policy,
Page 50 of a Monogram, IMM 100Rx Policy,
(No Supplemental Accident Benefit)
Page 63of a Monogram, IMM 100Rx Policy,
(SAB of $1,000)
Page 50 of an Autograph, HSAQ 100 Rx Policy,
(Single Deductible of $2,500 and Lifetime Max of $5,000,000))
Page 46 of an Autograph, HSAQ 100 Policy,
(Single Deductible of $5,200 and Lifetime Max of $2,000,000)
Page 62 of an Autograph, HSAQ 100 Rx Policy,
(Single Deductible of $5,000 and Lifetime Max of $5,000,000)
Page 50 of a Portrait IMM Policy,
(RX deductible of $500 and no SAB)
Page 50 of a Portrait IMM Policy
(No RX deductible), and
Page 50 of a Portrait Policy
(RX deductible of $500 and no SAB), reflect:

CHANGES TO THE POLICY

Your rights to make changes to the policy.

Adding Dependents

1. Coverage for a newborn child is automatic from the moment of birth when *we* receive notification or the application, as applicable. *We* will accept notification from the *covered person*, or the *covered person's agent or health care practitioner*. *We* must receive any required premium by the due date on the billing statement that includes the premium for newborn. Premium for the newborn is not required to be paid during the first 31 days. However, if the coverage for the newborn is to be continued beyond 31 days, *we* must receive notification and an application within 31 days.

Pages 45 of the AMP 250K, 75/55, 5K policy reflects:

CHANGES TO THE POLICY

Your rights to make changes to the policy

Adding dependents

- If a child is born to *you* or any *covered person*, *you* adopt a child, or a child is placed with *you* for the purpose of adoption *we* must be notified of the event in writing and receive any required premium within 31 days of the event to avoid medical underwriting. If *we* do not receive notice and premium for the first 31 days and forward, the child will not be a *covered person* under this *policy*.

Form Name	Form Number	Marketed
HDHP	CC2003-C	07/01/05-Not discontinued but stopped actively marketing 08/01/07
Humana HDHP 08	CC2003-C	12/15/07 to current
Humana PPO 08	CC2003-C	11/25/07 to current
Humana Coverage First 08	CC2003-C	10/01/07 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000))	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current

Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 38:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect the correct provisions under which coverage is to be provided for newborns as required by Colorado insurance law.

Issue E35: Failure, in some instances, to reflect correctly or completely required provisions that are substantially the same, more favorable or at least as favorable to the insured persons and more favorable to the policyholder.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

(1) Except as provided in section 10-16-204, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

…

(6)(a) Provisions as follows: "Notice of claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy *or as soon thereafter as is reasonably possible*. Notice given by or on behalf of the insured or the beneficiary to the insurer at…….. *(*insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer." [Emphases added.]

…

(12) A provision as follows: "Legal actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought *after the expiration of three years* after the time written proof of loss is required to be furnished." [Emphasis added.]

Section 10-16-214, C.R.S., Group sickness and accident insurance, states in part:

…

(3)(a) Except as provided for in subsection (2) of this section, *all policies of group sickness and accident insurance providing coverage to persons residing in the state shall contain in substance the following provisions or provisions which, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder*: [Emphasis added.]

(I) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due *except the first*, during which grace period the policy shall continue in force, unless the

policyholder has given the insurer written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the coverage was in force during such grace period. [Emphasis added.]

(II) A provision that the validity of the policy *shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue* and that no statement made for the purpose of effecting insurance coverage under the policy with respect to a person shall be used to avoid the insurance coverage with respect to which such statement was made or to reduce benefits under such policy after such insurance has been in force for a period of two years during such person's lifetime unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to the person making the statement or to the beneficiary of any such person; [Emphasis added.]

…

(III) A provision that no agent has authority to change the policy or waive any of its provisions and that no change in the policy shall be valid unless approved by an officer of the insurer, and evidenced by an endorsement on the policy or by rider or amendment to the policy signed by the insurer; *but any such amendment which reduces or eliminates coverage shall have been either requested in writing or signed by the policyholder*; [Emphasis added.]

…

(XIV) A provision that *no action at law or in equity shall be brought to recover on the policy prior to the expiration of the time requirements for payment pursuant to section 10-16-106.5* and after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy. [Emphasis added.]

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.

…

Section 10 First Level Review

…

D. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to Section 6 or 7 or after the receipt of notification of a benefit denied due to a contractual exclusion, a covered person may file a grievance with

> the health carrier requesting a first level review of the adverse determination. In order to secure a first level review after the receipt of the notification of a benefit denied due to a contractual exclusion, the covered person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply. [Emphasis added.]

HIC's Basic and Standard plans are not in compliance with Colorado insurance law in that the required provisions for group sickness and accident insurance stated in the plan are not substantially the same, more favorable or at least as favorable to the insured persons and the policyholder, or are incomplete in the following ways:

(1) Grace Period: The provision as stated does not reflect that a "grace period" does not apply to payment of the first premium.
(2) Incontestability: The use of "Any Policy provision", as an exception for contesting the validity of coverage in effect without interruption for two (2) years, is subject to more general interpretation than allowed by Colorado insurance law.
(3) Modification of Policy: The provision as stated does not reflect that any amendment which reduces or eliminates coverage shall have been either requested in writing or signed by the policyholder.
(4) Legal Actions: The provision reflects an incorrect description of when an action at law or equity can be brought to recover a claim. The expiration of time is what is required for payment and after proof of loss has been filed in accordance with the requirements of the policy pursuant to section 10-16-106.5, C.R.S., i.e., thirty (30) days for electronic submission and forty-five (45) days for paper submission of claims.
(5) Claim Appeal Procedure: The provision reflects an incorrect number of sixty (60) days within which an appeal must be submitted after receipt of notice of an adverse determination. Colorado insurance law allows 180 calendar days for a covered person to submit an appeal after receipt of notice of an adverse determination.

Page 72 of the Basic PPO Limited Mandate Health Benefit Plan,
Page 63 of the Basic Indemnity Limited Mandate Health Benefit Plan,
Page 71 of the Standard PPO Health Benefit Plan, and
Page 64 of the Standard Indemnity Health Benefit Plan reflect:

> **GENERAL PROVISIONS**
>
> **GRACE PERIOD**
>
> A grace period of 31 days will be allowed for payment of each premium due. Insurance will remain in force during the grace period. If the required premium is not paid by the end of the 31 day grace period, **Your** coverage will be terminated. If **We** receive written notification of termination in accordance with the Termination of Coverage section of this Certificate, prior to the end of the grace period, premium is due from the beginning of the grace period to the date notice is received or the termination date stated in the notice, whichever is later. **Your Employer** will be required to pay premium for the time coverage is effective during the grace period.

Page 68 of the Basic PPO Limited Mandate Health Benefit Plan,
Pages 59 and 60 of the Basic Indemnity Limited Mandate Plan,
Pages 67 and 68 of the Standard PPO Health Benefit Plan, and

Pages 60 and 61 of the Standard Indemnity Health Benefit Plan reflect:

INCONTESTABILITY

After **You** are insured without interruption for two years, **We** cannot contest the validity of **Your** coverage except for:

- Nonpayment of premium;
- **Your** ineligibility under the Policy;
- *Any Policy provision;*
- Any fraudulent misrepresentation made by **You;** or
- Any defenses **We** may have by law. [Emphasis added.]

Page 71 of the Basic Limited Mandate Benefit PPO Plan,
Page 62 of the Basic Indemnity Limited Mandate Plan,
Page 70 of the Standard PPO Health Benefit Plan, and
Page 63 of the Standard Indemnity Health Benefit Plan reflect:

MODIFICATION OF POLICY

Coverage provided under this Policy may be expanded through a rider or endorsement at any time, at the option of the **Employer**. No modification will be valid unless approved by **Our** President or Secretary. The approval must be endorsed on or attached to this Policy. No agent has authority to modify this Policy, or waive any of the Policy provisions, to extend the time of premium payment, or bind **Us** by making any promise or representation.

Page 70 of the Basic Limited Benefit PPO Plan,
Page 61 of the Basic Indemnity Limited Mandate Plan,
Page 69 of the Standard PPO Health Benefit Plan, and
Page 62 of the Standard Indemnity Health Benefit Plan reflect:

LEGAL ACTIONS

You *cannot bring an action at law or equity to recover a claim until 60 days after the date written proof of loss is made*. **You** cannot bring such action more than three years after such proof of loss is made. [Emphasis added.]

Page 68 of the Basic Limited Benefit PPO Plan,
Page 59 of the Basic Indemnity Limited Mandate Plan,
Page 67 of the Standard PPO Health Benefit Plan, and
Page 60 of the Standard Indemnity Health Benefit Plan reflect:

CLAIM APPEAL PROCEDURE

If **We** partially or fully deny a claim for benefits submitted by **You**, and **You** disagree or do not understand the reasons for this denial, **You** may appeal this decision. **You** have the right to:

- Request a review of the denial;
- Review pertinent plan documents; and
- Submit in writing, any data, documents or comments which are relevant to **Our** review of this denial.

Your *appeal must be submitted in writing within 60 days of receiving written notice of denial*.
We will review all information and send written notification within 60 days of **Your** request.
[Emphasis added.]

HIC's individual policies are not in compliance with Colorado insurance law in that some required provisions are incomplete or reflect incorrect information.

Incomplete

(1) Notice of Claim Provision

In the two (2) individual policies listed below, nothing is reflected to indicate that if written notice of the claim if not given to the insurer within thirty (30) days after the service was received, it may be given as soon thereafter as is reasonably possible.

Page 22 of the Short Term Medical-STM 100/75 Policy and
Page 27 of the AMP 250K, 75/55, 5K Policy reflect:

CLAIMS PAYMENT

Notifying us of your claim

We must receive a letter from the *covered person* or the provider informing *us* of the claim within 30 days from the date the *service* was received.

(2) Completing the Claim Form

Not reflected in the eleven (11) individual policies listed below, are the time periods of thirty (30) days after receipt of the claim for the carrier to request any additional information necessary for resolution of the claim and the thirty (30) calendar days to be allowed for the person receiving a request for such additional information to submit such information.

Short Term Medical-STM 100/75 Policy,
IMM OV Copay Policy,
AMP 250K, 75/55 5K Policy,
Monogram, IMM 100Rx Policy,
Monogram, IMM 100 Rx (SAB of $1,000),
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000),
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000),
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000),
Portrait IMM (RX deductible of $500 and no SAB) Policy,
Portrait IMM (No RX deductible) Policy, and
Portrait IMM ($1,000 SAB) Policy reflect:

Incorrect

(1) Legal Actions Provision

The eleven (11) individual policies listed below reflect that prior to bringing legal action a covered person must have also completed a second claim review, and utilized any external appeals procedure available under state law. A second level review is voluntary and an insured may choose to go straight from the first level review to an independent external review.

Page 24 of the Short Term Medical-STM 100/75 Policy,
Page 33 of the IMM OV Copay Policy,
Page 30 of the AMP 250K, 75/55, 5K Policy
Page 34 of the Monogram, IMM 100Rx Policy,
Page 43 of the Monogram, IMM 100 Rx (SAB of $1,000) Policy,
Page 34 of the Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000) Policy,
Page 32 of the Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000) Policy,
Page 42 of the Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000) Policy,
Page 34 of the Portrait IMM (RX deductible of $500 and no SAB) Policy,
Page 34 of the Portrait IMM (No RX deductible) Policy, and
Page 34 of the Portrait IMM ($1,000 SAB) Policy reflect:

CLAIMS PAYMENT

Rights you have after a second claim review and denial or
Rights You Have After a Second Claim Review and Denial

You cannot bring any legal action against *us* prior to 60 days but more than 2 years after the date all necessary claims payment information has been received. The *covered person* also must have completed a second claim review, and utilized any external appeals procedure available under state law or

You cannot bring any legal action against HIC prior to 60 days but more than 3 years after the date all necessary claims payment information has been received. The *covered person* also must have completed a second claim review, and utilized any external appeals procedure available under state law.

Form Name	Form Number	Marketed
CO Basic PPO Limited Mandate Plan	CO-57315-07 E BC	06/01/09 to 10/31/09
CO Basic Indemnity Limited Mandate Plan	CO-57315-07 BIN 3/2008	06/01/08 to current
CO Standard Indemnity Plan	CO-57315-07 E SIC	06/01/06 to current
CO Standard PPO Plan	CO-57315-07 E SPC	06/01/08 to current
Short Term Medical-STM 100/75	GN-71008-01 1/2008	3/6/09 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10

Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 39:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of §§ 10-16-202 and 10-16-214, C.R.S. and Colorado Insurance Regulation 4-2-17, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to correctly and completely reflect the provisions required by Colorado insurance law.

Issue E36: Failure, in some instances, to reflect that physical, occupational and speech therapy are a covered benefit without regard as to whether the purpose of the therapy is to maintain or to improve functional capacity.

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

. . .

(1.7) Therapies for congenital defects and birth abnormalities, states in part:

(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. [Emphasis added.]

(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*. [Emphasis 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 4. Requirements for Home Health Services

A. Definitions.

. . .

(2) "Home health services" means the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:

. . .

(d) *Physical therapy, occupational therapy or speech pathology* and audiology services, as such therapy and services are defined in C.R.S. [Emphasis added.]

Section 5. Requirements for Hospice Care

A. Definitions.

. . .

(2) "Hospice care" is an alternative way of caring for terminally ill individuals *which stresses palliative care as opposed to curative or restorative care*. [Emphasis added.]

. . .

C. Benefits for Hospice Care Services.

. . .

(3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:

. . .

(k) *Therapies including physical, occupational and speech.* [Emphasis added.]

HIC's individual policies are not in compliance with Colorado insurance law in that the coverage for physical, occupational and speech therapy indicates that these therapies are a covered benefit if they are provided to attain a previous level of function. This is more limiting than allowed by Colorado insurance law as these therapies are mandated benefits to be provided for (1) congenital defects and birth abnormalities and (2) hospice and home care services without regard as to whether the purpose of the therapy is to maintain or to improve functional capacity.

Page 19 of the Short Term Medical-STM 100/75 Policy,
Page 27 of the IMM-OV Copay Policy,
Page 23 of the AMP 250K, 75/55, 5K Policy,
Page 27 of the Monogram, IMM 100Rx (No Supplemental Accident Benefit) Policy,
Page 33 of the Monogram, IMM 100 Rx (SAB of $1,000) Policy,
Page 27 of the Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000) Policy,
Page 25 of the Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000) Policy,
Page 32 of the Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000) Policy,
Page 27 of the Portrait IMM (RX deductible of $500 and no SAB) Policy,
Page 27 of the Portrait IMM (No RX deductible) Policy, and
Page 27 of the Portrait IMM ($1,000 SAB) Policy, reflect:

YOUR POLICY BENEFITS

Physical medicine or
Physical Medicine

Outpatient services by a *healthcare practitioner* for the following:

- *Services* to restore speech or swallowing impairment and cognitive therapy pertaining to head injury or stroke to attain a previous level of function; and

- Other therapy *services* for rehabilitation of the loss to attain a previous level of function including, but not limited to, occupational therapy, physical therapy, cognitive therapy, audiology therapy, speech therapy, pulmonary therapy, cardiac rehabilitation, spinal manipulations and spinal adjustment modalities, or

- Other therapy *services* for rehabilitation of the loss to attain a previous level of function, including but not limited to: occupational therapy; physical therapy; spinal manipulation; and spinal adjustment modalities.

  Therapies for congenital defects and birth abnormalities as shown on the Schedule.

Form Name	Form Number	Marketed
Short Term Medical-STM 100/75	GN-71008-01 1/2008	3/6/09 to current
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (RX deductible of $500 and no SAB)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM (No RX deductible)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM ($1,000 SAB)	CO-70129 SCH 8/2002	4/21/07 to current

Recommendation No. 40:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-8, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect that physical, occupational and speech therapy are covered benefits without regard as to whether the purpose of the therapy is to maintain or to improve functional capacity as required by Colorado insurance law.

Issue E37: Failure to reflect in a Colorado Rider that if prior authorization is obtained, inpatient hospitalization is to be covered for dental care procedures provided to dependent children who meet certain criteria.

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. [Emphasis added.]

(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.

(b) A carrier may:

(I) Require prior authorization for general anesthesia and outpatient surgical facilities *or hospitalization* for dental care procedures in the same manner that prior authorization is required *for hospitalization* for other covered diseases or conditions; [Emphases added.]

HIC's "Colorado Rider", used as a base plan rider for two (2) of the individual policies reviewed, is not in compliance with Colorado insurance law in that it limits coverage to outpatient hospital care for dental procedures provided to dependent children who meet certain criteria. If prior authorization is obtained, hospitalization (inpatient) for these dental care procedures is to be covered also.

When attached, the Colorado Rider became page 57 of the policy and reflects:

> **Dental Procedures**
>
> Coverage will be provided for *outpatient hospital* care and general anesthesia for dental procedures for a covered *dependent* child if: [Underlined emphasis added.]
>
> - There is a physical, mental or medically compromising condition;
> - Local anesthesia is ineffective due to acute infection, anatomic variations or allergy;
> - The child is extremely uncooperative, unmanageable, anxious or uncommunicative and dental care cannot be deferred; or
> - There is extensive orofacial and dental trauma.

Form Name	Form Number
Colorado Rider	CO-71008-01 STM 1/2008

Recommendation No. 41:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-104, C. R. S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected its Colorado Rider and any other applicable forms to reflect that inpatient hospitalization for dental procedures for dependent children meeting certain criteria is a covered benefit as required by Colorado insurance law.

Issue E38: Failure, in some instances, to reflect acceptable reasons for termination of coverage.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states in part:

> (1) A carrier providing coverage under a health benefit plan shall not discontinue coverage or refuse to renew such plan *except for the following reasons*: [Emphasis added.]
>
> (a) Nonpayment of the required premium:
>
> (b) Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage;
>
> . . .
>
> (d)(I) The carrier elects to discontinue offering and nonrenew all of its individual, small group, or large group health benefit plans delivered or issued for delivery in this state. …
>
> . . .
>
> (f) With respect to individual health benefit plans, the commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders or certificate holders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations. …
>
> . . .
>
> (4) *An individual health benefit plan must clearly disclose in its contracts and marketing materials the conditions of renewability which conform with the requirements of this section.* [Emphasis added.]

HIC's individual policies are not in compliance with Colorado insurance law in that an unacceptable reason for termination is reflected.

Page 45 of the IMM-OV Copay Policy,
Page 40 of the AMP 250K, 75/55, 5K Policy,
Page 45 of the Monogram, IMM 100Rx (No Supplemental Accident Benefit) Policy,
Page 57 of the Monogram, IMM 100 Rx (SAB of $1,000) Policy,
Page 45 of the Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000) Policy,
Page 41 of the Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000) Policy,
Page 56 of the Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000) Policy,
Page 45 of the Portrait IMM (RX deductible of $500 and no SAB) Policy,
Page 45 of the Portrait IMM (No RX deductible) Policy, and
Page 45 of the Portrait IMM ($1,000 SAB) Policy reflect:

TERMINATION RIGHTS

Reasons we will terminate your policy.

This *policy is* renewable at the option of the *policyholder*, except for the conditions stated below. *We* will terminate *your policy* on the occurrence of the following events:

- *You* have not paid the premium by the end of the payment period.
- *You* or the *covered person* commit fraud or make an intentional misrepresentation of a material fact, as determined by *us.*
- *You* *move outside of the service area, as determined by* *us;* [Underlined emphasis added.]
- *You* request termination of the *policy* in writing, or the date such request is received by *us*, whichever is later.
- *We* have a right or defense to take such action by law.
- *We* cease to offer a type of *policy* or cease to do business in the individual medical insurance market, as allowed by state law.

Three (3) additional reasons reflected in the AMP 250K, 75/55, 5K policy:

- *You* or a *covered person* permit someone else to use *our ID card:*
- *You* or a *covered person* fail to comply with the *policy* provisions, as determined by *us;*
- *You* enter full-time military, naval or air service; [Underlined emphases added.]

Form Name	Form Number	Marketed
IMM-OV Copay	CO-70129 SCH 8/2002	1/20/03 Stopped Marketing 4/21/07
AMP 250K, 75/55, 5K	GN-71007-01 1/2008	9/27/08 Stopped Marketing 6/5/10
Monogram, IMM 100Rx (No Supplemental Accident Benefit)	CO-70129 SCH 8/2002	4/21/07 to current
Monogram, IMM 100 Rx (SAB of $1,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $2,500 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 (Single Deductible of $5,200 and Lifetime Max of $2,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Autograph, HSAQ 100 Rx (Single Deductible of $5,000 and Lifetime Max of $5,000,000)	CO-70129 SCH 8/2002	4/21/07 to current
Portrait IMM	CO-70129 SCH 8/2002	4/21/07 to current

(RX deductible of $500 and no SAB)		
Portrait IMM	CO-70129 SCH 8/2002	4/21/07 to current
(No RX deductible)		
Portrait IMM	CO-70129 SCH 8/2002	4/21/07 to current
($1,000 SAB)		

Recommendation No. 42:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-201.5, C. R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has developed, revised and/or corrected all applicable forms to reflect only valid reasons for terminating coverage as required by Colorado insurance law.

RATING

Issue F1: Failure to file or utilize rates filed with the Colorado Division of Insurance on individual policies as required by Colorado insurance law.

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.

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

I. Required Submissions:

a. *All companies must submit rate filings whenever the rates charged new or renewal policyholders or certificate holders 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. [Emphasis added.]

It appears HIC is not in compliance with Colorado insurance law in that it failed to file or use the rates that were submitted to the Colorado Division of Insurance. During the review of rate filings and tracing the rate factors to the premium calculations, it was noted that HIC used incorrect rating factors and monetary amounts for individual products as submitted to the Division for rate filings.

Among the unfiled rates used for the period under examination, HIC charged more than the filings of 1.4% on their 3000 Lite Deductible 80/60 Plan and 3.3% on the 2000 Lite Deductible 80/60 Plan in which refunds were made due to the discrepancy of the Colorado rate filings versus what was charged the insured as premium. This was corrected for rates effective for the January 1, 2010 rate filing.

In addition, Office Visit Co-pays that were added twice in the filings. The twenty percent (20%) Office Visit Co-pay error was systemic to all rate filings during the period under review (April 1, 2007-December 31, 2007, January 1, 2008-June 30, 2008, July 1, 2008-September 30, 2008, October 1, 2008-June 30, 2009) and the eighteen (18) month guarantee of rates for quarter only effective January 1, 2009.

Also, the April 1, 2007-December 31, 2007 rate filings showed a transposition error for the Lifetime Maximums (LTM) of one dollar ($1.00) for the first rate filing in the period under review (April 1, 2007-December 31, 2007) which was corrected in subsequent rate filings. The LTM buy-up to 5 million was $1.00 too low whereas the LTM buy up to 8 million was $1.00 to high. HIC also filed an incorrect region for Teller County. Therefore, HIC used unfiled rates during the period under review which is not in compliance with Colorado insurance laws.

Recommendation No. 43:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-107, C.R.S., and Colorado Insurance Regulation 4-2-11, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has reviewed and modified its procedures to file or utilize rates filed with the Colorado Division of Insurance on Individual policies as required by Colorado insurance law.

NEW BUSINESS APPLICATIONS & RENEWALS

Issue G1: Failure, in some instances, to define correctly a significant break in coverage.

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 §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., 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. [Emphasis added.]

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.]

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]

In some cases, HIC is not in compliance with Colorado insurance law in that the application for individual coverage completed by some applicants does not reflect the correct definition of a significant break in coverage as required under Colorado insurance law. The application and underwriting notes indicate HIC is using sixty-three (63) days rather than ninety (90) days to define a significant break in coverage as mandated under Colorado insurance law. This version of the individual application was not used during the entire examination period, but from the last quarter of 2008 through June 30, 2009.

Applications – Definition of "Significant Break in Coverage"
July 1, 2007 – June 30, 2009

Population	Sample	Incidence of Error	Percentage
13,954	116	27	23%

<u>Recommendation No. 44:</u>

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S. and Colorado Insurance Regulation 4-2-18, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has implemented procedures for its application form to reflect the correct number of days for a significant break in coverage as required by Colorado Law.

Issue G2: Failure to reflect all required information in application forms concerning replacement of coverage.

Colorado Insurance Regulation 4-2-1, Replacement of Accident and Sickness Insurance, promulgated under the authority of §§ 10-1-109 and 10-3-1110, C.R.S., states in part:

…

Section 2. Purpose

The purpose of this regulation is to safeguard the interests of persons covered by individual accident and sickness insurance policies or plans who consider replacement of their coverage by *making available to them information regarding replacement* and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance. [Emphasis added.]

…

Section 5. Rules

A. *Application forms shall include the following questions* designed to elicit information as to whether, as of the date of the application, the applicant has accident and sickness insurance in force or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used. [Emphasis added.]

[Statements]

(1) You normally do not require more than one policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.

(4) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

[Questions]

To the best of your knowledge:

…

(3) Are you covered for medical assistance through the state Medicaid program?

(a) As a Specified Low Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c) For other Medicaid medical benefits?

The application forms in use during the examination period do not appear to reflect the required "Statements or Question (3)" which makes pertinent information available to persons considering replacement of their coverage. No supplementary application or other form reflecting this information was provided to the examiners.

Recommendation No. 45:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-1, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has implemented procedures to ensure that all required information concerning replacement of coverage is reflected in its insurance application forms as required by Colorado insurance law.

Issue G3: Failure, in some instances, of proper use of underwriting criteria for small groups.

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

…

(40) (a) *"Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, except as provided in section 10-16-105 (12), employed no more than fifty eligible employees, the majority of whom were employed within this state and that was not formed primarily for the purpose of purchasing insurance. "Small employer" includes a business group of one.* In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. [Emphasis added.]

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

…

(12) *In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether such employer is a small or large employer shall be based on the average number of employees that is reasonably expected such employer will employ on business days in the current calendar year*. [Emphasis added.]

HIC does not appear to be in compliance with Colorado insurance laws, in that their underwriting criteria for small groups appears more restrictive than Colorado insurance law allows. In the review of information provided in HIC's Connections Newsletter, which was circulated to Colorado agents, HIC stated in part:

"Underwriting changes:
Feb. 1, 2009, new case effective dates
Employee-level health questions required
for all new business (1-99 employees)"

…

New case eligibility change (1-99)

To simplify the documentation requirements for recently started businesses, a business must be operational for a minimum of six months to be eligible for coverage with Humana Small business. This requirement will eliminate questions about businesses that may be too new to have filed payroll or a state wage and tax report." [Emphasis added.]

Recommendation No. 46:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of §§ 10-16-102 and 10-16-105, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has revised the eligibility documentation of all small groups as required by Colorado insurance law.

Issue G4: Use of a group policy issued to the Employers Health Insurance Benefit Trust, a non-approved Trust, to offer conversion plans to eligible individuals.

Section 10-16-214, C.R.S., Group sickness and accident insurance, states in part:

> (1) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without their dependents, and issued upon the following bases:
>
> (a) Under a policy issued to an employer, who shall be deemed the policyholder, insuring at least ten employees of such employer for the benefit of persons other than the employer. The term "employees", as used in part 1 of this article and this part 2, includes the officers, managers and employees of the employer.
>
> …
>
> (d) Under a policy issued to any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a group sickness and accident policy or contract.

HIC is not in compliance with Colorado insurance law in that it has established and continues to use a group policy issued to the Employers Health Insurance Benefit Trust to offer conversion plans to individuals who are eligible for conversion coverage. HIC was notified by the Colorado Division of Insurance, Rates and Forms Section, on multiple occasions that this Trust was disapproved in Colorado. The basis for the disapproval was that the Trust appeared to have been formed for the purpose of providing insurance, and that it did not meet the definition of a valid group in Colorado.

Recommendation No. 47:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-214, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has discontinued use of the group policy issued to the Employers Health Insurance Benefit Trust to offer conversion plans to eligible individuals as required by Colorado insurance law.

CANCELLATIONS/NON-RENEWALS/DECLINATIONS/RESCISSIONS

Issue H1: 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 HIC 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.

The examiners reviewed a random sample of 114 files of individual new business applications that were declined from a population of 2,592. In fourteen (14) or 12% of the files reviewed, HIC failed to provide the required notifications to individual applicants who were denied coverage under an individual plan, and self-identified at the time of application as being a business group of one.

The incidence of error is as follows:

New Business Application Declinations
July 1, 2007-June 30, 2009

Population	Sample	Number of Exceptions	Percentage
2,592	114	14	12%

Recommendation No. 48:

No later than thirty (30) days from the date this report is adopted, HIC should provide written documentation demonstrating why it should not be considered in violation of § 10-16-105.2, C.R.S., and Colorado Insurance Regulation 4-2-19, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it will provide written notice of the availability of small group coverage to business groups of one upon denial of coverage under an individual plan as required by Colorado insurance law.

Issue H2: Failure, in some instances, to reflect a definition of "significant break in coverage" on Certificates of Creditable Coverage.

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.

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under the authority of §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., 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. [Emphasis added.]

…

Section 5. Rules

…

B. Colorado law concerning creditable coverage. 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.

1. 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.]

2. 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.

3. 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.]

The certificate of prior creditable coverage provided to individuals whose coverage was cancelled was not in compliance with Colorado insurance law in that the form did not reflect the definition of "significant break in coverage" as required by Colorado insurance law. Failure to include this required information in the Certificates of Prior Creditable Coverage sent to insureds whose coverage had been cancelled, may prevent those individuals from becoming aware of the rules regarding creditable coverage and the time limit for obtaining replacement coverage in order to avoid the application of preexisting exclusions.

In addition, HIC is implying that this certificate would allow the former insured guaranteed coverage as well as a policy that would not be subject to exclusions for medical conditions at the time of enrollment. This language would apply to group coverage, but not necessarily to individual coverage.

HIC's Certificate of Prior Health Coverage states:

"CERTIFICATE OF PRIOR CREDITABLE COVERAGE
Important Information to Keep with Your Personal Records

The Health Insurance portability and Accountability Act of 1996 (HIPAA) mandates health plans to provide former participants and beneficiaries with a certificate of written evidence of prior heath coverage. You may need to provide this certificate for the following:

*To reduce the preexisting condition exclusion period when becoming eligible under a health plan.
**To purchase new health insurance on a guaranteed basis.*

> **To purchase, for yourself or your family, an insurance policy that does not exclude coverage for the medical conditions that are present before you enroll.*" [Emphases added]

Finally, for individuals of small groups cancelling coverage, HIC used a letter instead of an actual Certificate of Creditable Coverage to show prior creditable coverage with HIC. Neither the Certificates of Prior Creditable Coverage nor the letters that were provided to show creditable coverage included a definition of a significant break in coverage.

The incidence of error on applications is as follows:

Individual and Small Group Cancellations
July 1, 2007-June 30, 2009

Business Type	Population	Sample Size	Incidence of Error	Percentage to Sample
Individual	11,438	116	116	100%
Small Group	1,201	114	114	100%

Recommendation Number 49:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has corrected its practice and that there is a definition of "significant break in coverage" on its Certificates of Creditable Coverage, as required by Colorado insurance law.

Issue H3: Failure, in some instances, to return unearned premium to the insured but in no event more than forty-five days after the effective date of any notification of cancellation or termination or as otherwise established.

Section 10-2-704, C.R.S., Fiduciary responsibilities, states in part:

…

(2) *Every insurer shall remit unearned premiums to the insured or the proper agent, or shall otherwise credit the account of the proper licensee, as soon as is practicable after the entitlement thereto has been established, but in no event more than forty-five days* after the effective date of any cancellation or termination effected by the insurer or *after a date of entitlement thereto as established by notification of cancelation or of termination* or as otherwise established. It shall be the responsibility of any insurance producer having knowledge of a failure on the part of any insurer to comply with this subsection (2) to promptly report such failure to the commissioner in writing. [Emphasis added.]

It appears HIC is not in compliance with Colorado insurance law in that, in some instances, it failed to return unearned premium to the insured in a timely manner.

The examiners reviewed thirty-six (36) files of rescinded contracts during the examination period. In five (5) or 14% of the files reviewed, HIC failed to return the unearned premium to the insured within forty-five (45) days after notification of rescission, cancellation, termination or as otherwise established.

The incidence of error is as follows:

Rescissions
July 1, 2007-June 30, 2009

Population	Sample	Number of Exceptions	Percentage
36	36	5	14%

Recommendation No. 50:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-2-704, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has corrected its procedures for the return of unearned premium to the insured in no event more than forty-five (45) days after the effective date of any notification of cancellation or termination effected by the insurer, as required by Colorado insurance law.

Issue H4: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan.

Section 10-16-108(4), 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.]

The incidence of error is as follows:

Cancelled Small Group Policies
July 1, 2007-June 30, 2009

Population	Sample Size	Number of Exceptions	Percentage of Sample
104	79	50	63%

The examiners reviewed a sample of seventy-nine (79) files randomly selected from a population of 104 small groups whose coverage cancelled due to non-payment of premium or cancelled by the employer without a stated reason during the exam period of July 1, 2007 through June 30, 2009. HIC is not in compliance with Colorado insurance law in that in fifty (50) cases (63% of the sample), HIC failed to offer members of the terminating small group a choice of the basic or standard health benefit plan as required by Colorado insurance law. There was no indication in any of the cited cases that the group's coverage had been replaced with another group plan.

Recommendation No. 51:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of §10-16-108(4), C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has corrected its small group procedures to offer employees of terminated group health plans the opportunity of conversion coverage as required by Colorado insurance law.

CLAIMS

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

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. [Emphasis added.]

. . .

(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.

(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). [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.]

HIC is not in compliance with Colorado insurance law in that twenty-nine (29) of 109 claims randomly selected from the total population of 24,325 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.

ELECTRONIC CLAIMS ADJUDICATED 30 DAYS OR MORE AFTER RECEIPT

Population	Sample Size	Number of Exceptions	Total Error Rate
24,325*	109	29	27%

(*1.7% of all electronic claims processed.)

HIC is not in compliance with Colorado insurance law in that it failed to pay, deny or settle 10 of 76 claims randomly selected from a total population of 145 claims not paid, denied or settled within the required ninety (90) calendar days. 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.

CLAIMS ADJUDICATED 90 DAYS OR MORE AFTER RECEIPT

Population	Sample Size	Number of Exceptions	Total Error Rate
145*	76	10	13%

(*<1% of all claims processed.)

Recommendation No. 52:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event HIC is unable to show such documentation, it shall provide written evidence to the Division that it has reviewed and modified its claims processing quality controls to ensure that all claims are adjudicated within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to properly investigate, adopt, and implement reasonable standards for the prompt resolution of medical payment claims and hold covered persons harmless for nonparticipating provider fees, as required by 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:

…

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

…

(XVII) *Failing to adopt and implement reasonable standards for the prompt resolution of medical payment claims.* [Emphasis added.]

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration, states in part:

…

(2)(a) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit *at no greater cost to the covered person than if the benefit were obtained from participating providers*. [Emphasis added.]

…

(c)(I) In cases where, as a result of the provisions of subparagraph (I) of paragraph (b) of this subsection (2), a covered person is required to travel a reasonable distance beyond the requirements of subsection (6) of this section for an adequate network in order to receive services from a participating provider, and the covered person knowingly seeks services from a nonparticipating provider, *the carrier shall be responsible to pay the provider the lesser of*:

(A) *The nonparticipating provider's bill charges;*

(B) A negotiated rate; or

(C) In the absence of a negotiated rate, the greater of the carrier's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area. Nothing in this paragraph (c) shall require either a carrier or a

nonparticipating provider to attempt to negotiate a reimbursement rate.

…

(III) *A nonparticipating provider may balance bill the covered person in the event that the reimbursement rate described in subparagraph (I) of this paragraph (c) is not equal to the billed charges.*

…

(f)(I) *"Balance bill" means the amount that a nonparticipating provider may charge the covered person. Such amount charged equals the difference between the amount paid by the carrier and the amount of the nonparticipating provider's bill charge.*

…

(III) *"Usual, customary, and reasonable rate" means a rate established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.* [Emphases added.]

…

(3)(a)(I) In 1997, the general assembly enacted this part 7 with the express intent to incorporate consumer protections into the creation and maintenance of provider networks and to establish standards to assure the adequacy, accessibility, and quality of health care services offered under a managed care plan.

(II) The general assembly hereby finds, determines, and declares that there are situations in which *insured consumers receive health care services, including procedures approved by their insurance carrier, in a network facility, with a primary provider that is a network provider, but in which other health care professionals assisting with such procedures may not be in-network providers. In such situations, the consumer is not aware that the assisting providers are out-of-network providers. Further, the consumer may have little or no direct contact with the assisting health care professionals. The division of insurance has interpreted the network adequacy provisions in this section, along with the provisions related to relationships between an insurer and a health care provider in section 10-16-705, to hold the consumer harmless for additional charges from out-of-network providers for care rendered in a network facility.* The division of insurance's interpretation of these statutes was challenged by an insurer and invalidated by a division of the Colorado court of appeals in Pacific Life & Annuity Co. v. Colorado Div. of Ins., no. 04CA2169 (slip op.) (Feb. 23, 2006). [Emphasis added.]

(III) The general assembly finds, determines, and declares that the division of insurance has correctly interpreted the provisions of this section *to protect the insured from the additional expense charged by an assisting provider*

who is an out-of-network provider, and has properly required insurers to hold the consumer harmless. The division of insurance does not have regulatory authority over all health plans. Some consumers are enrolled in self-funded health insurance programs that are governed under the federal "Employee Retirement Income Security Act". Therefore, the general assembly encourages health care facilities, carriers, and providers to provide consumers disclosure about the potential impact of receiving services from an out-of-network provider. [Emphasis added.]

(IV) The general assembly finds, determines, and declares that some consumers intentionally use out-of-network providers, which is the consumers' prerogative under certain health benefit plans. When consumers intentionally use an out-of-network provider, the consumer is only entitled to benefits at the out-of-network rate and may be subject to balance billing by the out-of-network provider.

(V) Therefore, the general assembly finds, determines, and declares that the purpose of Senate Bill 06-213 is to codify the interpretation of the division of insurance that *holds consumers harmless for charges over and above the in-network rates for services rendered in a network facility*. [Emphasis added.]

(b) When a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit. Covered services or treatment rendered at a network facility, including covered ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, shall be covered *at no greater cost to the covered person* than if the services or treatment were obtained from an in-network provider. [Emphasis added]

Number of Exceptions	Number of Unpaid Provider Claims	Number of Claims Subject to Balance Billing	Denial Reason
34	11	33	This service was performed by a nonparticipating provider. The charge amount billed by your provider exceeds the Maximum Allowable Fee (MAF). You are responsible for the difference between the MAF a…
1	1	1	This service was processed according to the non-network level of benefits. The charge amount billed by your provider exceeds the Maximum Allowable Fee (MAF). You are responsible for the difference between…

At the request of the Division due to a complaint received, the examiners reviewed 84 out-of-network assistant surgeon claims made during the examination period. In the absence of a negotiated rate, the nonparticipating provider may bill the covered person in the event the reimbursement rate does not equal billed charges. HIC reached an agreement with the Division (Employer's Health) in 1999 (letter to Alan Patek, dated May 19, 1999), and supported in Bulletin B-4.25 (May 8, 2007) where it is clarified that a

carrier is required to "…ensure that the covered person obtains the covered benefit at no greater cost than if the service was obtained from participating providers." However, as shown on the accompanying spreadsheet, HIC has advised 35 of its members that they are responsible for payment of fees in excess of HIC's Maximum Allowable Fee (MAF). Additionally, the spreadsheet identifies twelve (12) provider claims that have yet to be settled.

Recommendation No. 53:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, and 10-16-704, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has reviewed and modified its claims processing quality controls to ensure that all claims are properly investigated, and that HIC has adopted, and implemented reasonable standards for the prompt resolution of medical payment claims and holds covered persons harmless for nonparticipating provider fees, when required by Colorado insurance law.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level review appeals.

Section 10-16-113, C.R.S., Procedure for denial of benefits – interenal review – rules, states in part:

. . .

(3)(b)(V) The first-level appeal shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer; except that, in the case of dental care, the firs-level appeal may be evaluated by a dentist, who shall consult with appropriate clinical peer or peers, unless the reviewing dentist is a clinical peer. The physician or dentist and clinical peers shall not have been involved in the initial adverse determination. A person who was previously involved with the denial may answer questions.

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

. . .

E. Conduct of first level reviews.

. . .

2. *First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer.* The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions. [Emphasis added]

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 of July 1, 2007 to June 30, 2009.

HIC did not meet the requirements of Colorado insurance law in that in all seventy-nine (100% of the sample) first-level utilization review decisions, the files did not reflect a consultation with an appropriate clinical peer. In addition, it did not appear that the physician that performed the review was considered a clinical peer for the condition that was the subject of the review.

Utilization Review First Level Appeals
July 1, 2007- June 30, 2009

Population	Sample Size	Number of Exceptions	Total Error Rate
200	79	79	100%

Recommendation No. 54:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. and Colorado Insurance Regulation 4-2-17, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has implemented procedures to ensure that a physician shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer, evaluates all first level utilization reviews in accordance with Colorado law.

Issue K2: Failure, in some instances, to provide notification of the first level utilization review decision within the time period required by Colorado insurance law.

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**
>
> . . .
>
> G. Notification Requirements.
>
> . . .
>
> 3. *With respect to a request for a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision* within a reasonable period of time that is appropriate given the covered person's medical condition, but *no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review.*
>
> 4. *With respect to a request for a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision* within a reasonable period of time that is appropriate given the covered person's medical condition, but *no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review.* [Emphases added.]

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 of July 1, 2007 to June 30, 2009.

HIC did not meet the requirements of Colorado insurance law in that in six (6) of the seventy-nine (79) (8% of the sample) first-level utilization reviews, notification of the review decision was not provided within thirty (30) days after receipt of the grievance requesting the first level review.

Utilization Review First Level Appeals
July 1, 2007- June 30, 2009

Population	Sample Size	Number of Exceptions	Total Error Rate
200	79	6	8%

Recommendation No. 55:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has revised its procedures to ensure that all first-level utilization reviews, notification of the review decision is provided within the time period required by Colorado law.

Issue K3: Failure, in some instances, to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.

Section 10-16-113, C.R.S., Procedure for denial of benefits-rules, states in part:

. . .

(4) All written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient *shall be signed by a licensed physician* familiar with standards of care in Colorado. [Emphasis added.]

HIC provided the examiners files from which a random sample of seventy-nine (79) first-level utilization review appeal files initiated by covered persons or their representative(s) during the examination period of July 1, 2007 to June 30, 2009 were drawn.

HIC did not meet the requirements of Colorado insurance law in that fifteen (15) of seventy-nine (79) (19% of the sample) first-level utilization review denial decision letters were signed by a Specialist or Grievance and Appeal Specialist and not by a licensed physician familiar with standards of care as required under Colorado insurance law.

The following shows the incidence of error during the review:

Utilization Review First Level Appeals
July 1, 2007- June 30, 2009

Population	Sample Size	Number of Exceptions	Total Error Rate
200	79	15	19%

Recommendation No. 56:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has revised its first level review decision notification letter provided to the covered person and/or their representative(s), to include the physician signature as required by Colorado insurance law.

Issue K4: Failure 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 pursuant to §§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. [Emphases added.]

The examiners reviewed HIC's entire population of seven (7) external review files. HIC is not in compliance with Colorado insurance law in that its external review files, in some instances, do not meet the requirements set forth in Colorado Insurance Regulation 4-2-21 for the following reasons:

- In three (3) out of the seven (7) files reviewed, there was no record found of HIC's delivery of notice of an external review request to the Division of Insurance within the required two days. In all seven (7) files reviewed, there was no record found of HIC's electronic (including via facsimile) or telephonic notification to the covered person/designated representative of the External Review entity selected within the two (2) working days as required under Colorado insurance law.

Utilization Review External Appeals
July 1, 2007- June 30, 2009

	Population	Sample Size	Number of Exceptions	Total Error Rate
Notice to Division	7	7	3	43%
Notice to Covered Person	7	7	7	100%

Recommendation No. 57:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-21, which is promulgated under the Commissioner's authority set forth at § 10-1-109(1) C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has revised its procedures comply with the notification requirements pertaining to an External Review as required by Colorado insurance law.

Issue K5: Failure, in some instances to include correct information regarding preauthorization in utilization review approval letters.

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 10-16-704, C.R.S., Network Adequacy, states in part:

…

(4) *When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse.* If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person. [Emphasis added.]

Colorado Division of Insurance Bulletin No. B-4.13 Preauthorization for Treatments or Procedures by Health Plans issued May 8, 2007, states in part:

I. Background and Purpose

… Carriers often contract with third party to perform medical necessity or utilization review. The results of these reviews are often provided to the insureds or their providers before the carrier has made its coverage determination. In an attempt to reserve the right to make a subsequent coverage determination, the initial notification sometimes contains disclaimer language stating that coverage is contingent upon a subsequent level of review.

After notification of approval at the initial review for medical necessity, some carriers are later denying coverage for the treatment or procedure which was the subject of the initial approval.

. . .

III. Division Position

Colorado law states that once a carrier has "preauthorized" a treatment or procedure, the carrier cannot retrospectively deny the treatment of procedure, except for fraud and abuse, even where the benefit is not covered under the plan. See § 10-16-704(4), C.R.S. In addition, the statute prohibits the carrier from imposing a penalty on the insured for coverage of the benefit where the treatment or procedure was preauthorized. Covered persons and providers often do not distinguish between a medical necessity determination and a coverage determination, and act upon the initial medical necessity determination alone.

To avoid any confusion between the types of determination, the Division interprets this statute to mean that whenever a treatment or procedure is approved, irrespective of the terminology used by the carrier when reviewing the claim (e.g., precertification, preauthorization, medical necessity or utilization review), the carrier cannot subsequently deny coverage. In other words, it is incumbent upon the carrier to make its coverage determination prior to the delivery of any medical necessity determination or other form of preauthorization to the covered person or their provider. The exceptions are for fraud and abuse or where the insured loses coverage after approval, but before actually obtaining the treatment or procedure. In addition, the carrier cannot reduce the benefit which as subject to the initial review in any manner, such as by requiring the insured to pay a higher co-pay than would normally be due under the plan. [Emphasis added.]

Carriers cannot avoid the statutory requirement by including a disclaimer in the notice initially approving the treatment or procedure. For example, a carrier cannot notify a provider and or insured that a particular treatment or procedure has passed a certain level of review, but final approval is contingent upon additional review. To do so is a violation of the intent of the statute to prohibit retrospective denials after "preauthorization."

APPROVED DECISIONS – WRITTEN CONFIRMATION

Population	Sample Size	Number of Exceptions	Total Error Rate
4,103	115	115	100%

The examiners reviewed the sample of 115 utilization review approvals made during the examination period. In all 115 instances, HIC was not in compliance with Colorado insurance law in that the letter of approval of services provided to the provider and/or covered person implies that the claim *may* be retrospectively denied for reasons other than those provided for in § 10-16-704(4), C.R.S. The lack of clarity of the letter and the phrase "*Any payment or coverage is subject to all plan provisions*" appear to constitute a deceptive practice or act.

Further, the letter's implied message that a claim may be denied subsequent to preauthorization for treatment for procedures or services that are not covered benefits under the plan is contrary to the requirements of Colorado insurance law that states the carrier shall provide the benefits as authorized with no penalty to the covered person.

HIC's preauthorization of services letter states in part:

"LETTER OF APPROVAL OF SERVICES

Humana values our relationship with our members, and our goal is to provide exceptional customer service. We would like to take this opportunity to explain the approval of [covered person's] inpatient admission at [facility] on 1/1/2009 through 1/5/2009, for a total of 4 days.

We have determined that the services requested are Medically Necessary as defined in the Benefit Plan Document. Any payment or coverage is subject to all plan provisions

If you would like to contact our office regarding this or future services, please utilize the precertification phone number on the back of your ID card. If you are speech or hearing impaired, please call 1-800-325-2025. We are available Monday through Friday, 8:00 a.m. until 6:00 p.m.".

HIC disagreed with this comment, but agreed to modify their letter to the member and/or provider.

HIC stated, "We disagree that we are in violation of this regulation as we do not retrospectively deny services that were preauthorized and approved. In addition there are policies and procedures in place when processing submitted claims for payment to ensure that preauthorized services are allowed and not denied retrospectively.

In order to ensure that there is no misunderstanding and HIC's intent is clear when issuing a letter to our member and/or provider confirming the approval of their request for preauthorization of services we will remove the phrase "*Any payment of coverage is subject to all plan provisions*" or any variation of this statement from our approval letters."

Recommendation No. 58:

No later than thirty (30) days from the date this report is adopted, HIC shall provide written documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-704, C.R.S. In the event HIC is unable to provide such documentation, it shall provide written evidence to the Division that it has revised letter to ensure that there is no misunderstanding in the confirmation of the approval of preauthorization of services as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES	Rec. No.	Page No.
COMPANY OPERATIONS – MANAGEMENT		
Issue A1: Failure, in some instances, to maintain records required for market conduct purposes.	1	20
Issue A2: Certifying and Using Non-Compliant Forms. *(This was prior issue A1 in the findings of the 2002 final examination report.)*	2	21
Issue A3: Failure to maintain a document meeting the requirements and definition of an Access Plan.	3	22
CONSUMER COMPLAINTS		
Issue C1: Failure to maintain a complete record of all complaints received.	4	25
CONTRACT FORMS		
Issue E1: Failure to reflect coverage for early intervention services in individual and small group plans.	5	29
Issue E2: Failure to indicate mammograms and prostate screening are not covered in basic limited mandate health benefit plans.	6	34
Issue E3: Failure to correctly title the Basic Health Benefit Plans as "Limited Mandate" plans.	7	37
Issue E4: Failure to reflect correct annual maximum for durable medical equipment in the Basic PPO Limited Mandate Health Benefit Plan.	8	42
Issue E5: Failure to exempt child health supervision services from a deductible when services are provided by a non-network provider.	9	47
Issue E6: Failure to reflect that preauthorization is the sole responsibility of the participating provider.	10	52
Issue E7: Failure, for a period of time, to reflect correct out-of-pocket annual maximums in the Standard Indemnity Health Benefit Plan.	11	57
Issue E8: Failure to reflect a complete and correct description of when pre-existing condition exclusions apply.	12	64
Issue E9: Failure to reflect correctly the extent of coverage to be provided for home health services and hospice care.	13	74
Issue E10: Failure to reflect in the Basic and Standard Plans a correct definition of and the coverage to be provided for emergency care.	14	83
Issue E11: Failure to provide reimbursement for covered services when lawfully performed by a licensed provider that either resides in the insured's home or who is a family member. (*This was prior Issue E6 in the final 2002 examination report*).	15	86
Issue E12: Failure, in some instances, to reflect correct or complete outpatient coverage benefits to be provided for treatment of alcoholism.	16	88
Issue E13: Failure, in some instances, to reflect correct requirements for emergency admission notification.	17	90
Issue E14: Failure, in some instances, to reflect correct benefits for	18	94

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mammograms.		
Issue E15: Failure, in some instances, to allow for other single and multi-organ transplants not specifically listed if they are determined to be medically necessary and meet clinical standards for the procedure.	19	102
Issue E16: Failure, in some instances, to reflect correct pre-existing condition limitations.	20	104
Issue E17: Failure to reflect correct "absence from work" termination of coverage provisions in Basic and Standard plans.	21	108
Issue E18: Failure, in some instances, to reflect the correct procedures for conducting utilization review.	22	116
Issue E19: Failure, in some instances, to allow coverage for hearing aids for dependent children under the age of eighteen (18) years.	23	124
Issue E20: Failure, in some instances, to reflect correct coverage provisions for emergency care to be provided.	24	126
Issue E21: Failure, in some instances, to provide coverage for treatment or benefits as a result of attempted suicide or intentionally self-inflicted injury whether sane or insane.	25	128
Issue E22: Failure, in some instances, to allow coverage to continue for an insured based solely on that individual's membership in the uniformed services of the United States.	26	130
Issue E23: Failure to reflect all required disclosures in short-term limited duration health insurance applications.	27	132
Issue E24: Failure, in some instances, to reflect complete or correct benefits to be provided for child health supervision services.	28	138
Issue E25: Failure, in some instances, to reflect complete or correct benefits to be provided for prostate cancer screening.	29	143
Issue E26: Failure, in some instances, to reflect the mandated coverage for cervical cancer vaccinations.	30	145
Issue E27: Failure, in some instances, to reflect the correct upper age limit for medically necessary therapy to be provided for congenital defects and birth abnormalities.	31	149
Issue E28: Failure, in some instances, to reflect that coverage is to be provided for replacement of prosthetic devices unless necessitated by misuse or loss.	32	151
Issue E29: Failure, in some instances, to reflect correct or complete grievance and appeal procedures.	33	158
Issue E30: Failure, in some instances, to clearly reflect the mandated coverage for complications of pregnancy and childbirth.	34	160
Issue E31: Failure to reflect correct coverage to be provided for newborns in a maternity rider.	35	164
Issue E32: Failure, in some instances, to reflect correct out-patient benefits for mental illness.	36	166
Issue E33: Failure to disclose counties of the state where there are no participating providers and to disclose in bold-faced type the disclosure concerning balance billing.	37	168
Issue E34: Failure, in some instances, to reflect the correct provisions	38	173

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under which coverage is to be provided for newborns.		
Issue E35: Failure, in some instances, to reflect correctly or completely required provisions that are substantially the same, more favorable or at least as favorable to the insured persons and more favorable to the policyholder.	39	180
Issue E36: Failure, in some instances, to reflect that physical, occupational and speech therapy are a covered benefit without regard as to whether the purpose of the therapy is to maintain or to improve functional capacity.	40	184
Issue E37: Failure to reflect in a Colorado Rider that if prior authorization is obtained, inpatient hospitalization is to be covered for dental care procedures provided to dependent children who meet certain criteria.	41	186
Issue E38: Failure, in some instances, to reflect acceptable reasons for termination of coverage.	42	189
RATING		
Issue F1: Failure to file or utilize rates filed with the Colorado Division of Insurance on individual policies as required by Colorado insurance law.	43	192
NEW BUSINESS APPLICATIONS & RENEWALS		
Issue G1: Failure, in some instances, to define correctly a significant break in coverage.	44	195
Issue G2: Failure to reflect all required information in application forms concerning replacement of coverage.	45	197
Issue G3: Failure, in some instances, of proper use of underwriting criteria for small groups.	46	199
Issue G4: Use of a group policy issued to the Employers Health Insurance Benefit Trust, a non-approved Trust, to offer conversion plans to eligible individuals.	47	200
UNDERWRITING – CANCELLATIONS/NONRENEWALS/ DECLINATIONS		
Issue H1: 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.	48	203
Issue H2: Failure, in some instances, to reflect a definition of "significant break in coverage" on Certificates of Creditable Coverage.	49	206
Issue H3: Failure, in some instances, to return unearned premium to the insured but in no event more than forty-five days after the effective date of any notification of cancellation or termination or as otherwise established.	50	207
Issue H4: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan.	51	208
CLAIMS		
Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.	52	211
Issue J2: Failure, in some instances, to properly investigate, adopt, and	53	215

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implement reasonable standards for the prompt resolution of medical payment claims and hold covered persons harmless for nonparticipating provider fees, as required by Colorado insurance law.		
UTILIZATION REVIEW		
Issue K1: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level review appeals.	54	218
Issue K2: Failure, in some instances, to provide notification of the first level utilization review decision within the time period required by Colorado insurance law.	55	220
Issue K3: Failure, in some instances, to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.	56	221
Issue K4: Failure to comply with the notification requirements pertaining to an External Review.	57	223
Issue K5: Failure, in some instances to include correct information regarding preauthorization in utilization review approval letters.	58	226

Examination Report Submission

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