

**MARKET CONDUCT EXAMINATION REPORT**  
**AS OF DECEMBER 31, 1998**

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**Aetna U.S. Healthcare, Inc.**  
**6430 S. Fiddlers Green Circle, Suite 200**  
**Englewood, CO 80111**

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**NAIC Group Code 0001**  
**NAIC Company Code 95256**  
**Employer's ID Number 84-1312793**

**EXAMINATION PERFORMED BY**  
**DIVISION OF INSURANCE STAFF**  
**DEPARTMENT OF REGULATORY AGENCIES**  
**STATE OF COLORADO**

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**State Market Conduct Examiners**

March 3, 2000

The Honorable William J. Kirven III  
Commissioner of Insurance  
State of Colorado  
1560 Broadway, Suite 850  
Denver, Colorado 80202

Commissioner:

This market conduct examination of Aetna U.S. Healthcare, Inc., was conducted pursuant to Section 10-16-416, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine health maintenance organizations. We examined the Company's records at its offices located at 6430 S. Fiddlers Green Circle, Suite 200, Englewood, Colorado, 80111. The market conduct examination covered the period from January 1, 1998, through December 31, 1998.

The results of the examination are respectfully submitted by the following state market conduct examiners.

John J. Postolowski, CIE, MA, FLMI, ACS

Jeffory Olson, ALHC

Yvonne Sainsbury, BA, AIRC

Mary Drake, AIE, FLMI

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OF  
Aetna U.S. Healthcare, Inc.**

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**COMPANY PROFILE**

The Company provided the following history:

Aetna U.S. Healthcare, Inc. (Colorado) is a wholly owned subsidiary of Aetna Inc. and the result of the acquisition and name change of Frontier Community Health Plans, Inc. (FCHP).

June 1995 FCHP was incorporated as a Colorado corporation with its principal place of business in Colorado. It was a wholly owned subsidiary of Frontier Health Holdings, Inc., a Delaware corporation (FHH).

July 1995 The Colorado Division of Insurance granted FCHP a license to operate as a health maintenance organization (HMO).

July 19, 1996 Aetna U.S. Healthcare Inc., a Pennsylvania corporation, was formed as the result of the merger of Aetna Life and Casualty Company and U.S. Healthcare. Aetna Inc. is the parent company of Aetna U.S. Healthcare, Inc.

January 6, 1997 Primary Investments, Inc., a Delaware corporation (PII), acquired FCHP by buying all of FHH's outstanding capital stock. PII is a wholly owned subsidiary of Primary Holdings, Inc., a Delaware corporation, which in turn is a wholly owned subsidiary of Aetna Inc.

February 3, 1997 The Colorado Division of Insurance approved the change of control and acquisition of FCHP by PII. The acquisition was completed on February 5, 1997.

April 22, 1997 The Colorado Division of Insurance approved the change in FCHP's name to Aetna U.S. Healthcare of Colorado, Inc.

The Company's name was changed from Aetna US Healthcare of Colorado, Inc. to Aetna US Healthcare Inc., a Colorado Corporation (the Plan) in September 1998.

1998 Market Share : .72%

1998 Written Premium: \$18,457,000

Membership: 28,119, which grew from 5,011 as of December 31, 1997

The Company is authorized to do business in the following twelve Colorado counties: Adams, Arapahoe, Boulder, Denver, Douglas, Elbert, El Paso, Fremont, Larimer, Jefferson, Pueblo, and Teller.

The provider network includes independent physicians, medical groups, hospitals, and ancillary providers. The majority of providers are reimbursed on a capitated basis. Reimbursement for laboratory services during 1998 was based on a reasonable and equitable fee schedule, but changed to a capitated basis in January of 1999. Magellan Behavioral Health is the vendor for all mental health and substance abuse claims.

**PURPOSE AND SCOPE OF EXAMINATION**

State market conduct examiners with the Colorado Division of Insurance (DOI), in accordance with Colorado Insurance Law, Sections 10-1-201, 10-1-203, 10-1-204 and specifically 10-16-416, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Aetna U.S. Healthcare, Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

Examiners performed this market conduct examination on a routine basis to assist the Colorado Commissioner of Insurance in meeting statutory examination requirements. The purpose of the examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to small group insurance reform laws. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The market conduct examination covered the period from January 1, 1998, through December 31, 1998.

The limited examination included review of the following:

- Company Operations / Management
- Marketing and Sales
- Complaints
- Contract Forms
- Rating
- Applications
- Cancellations / Non-Renewals / Declinations
- Claims
- Utilization Review

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

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

**EXAMINERS' METHODOLOGY**

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations as they pertain to health maintenance organizations. For this examination, special emphasis was given to Health Maintenance Organization reform, small group reform, and the laws and regulations as shown in Exhibit 1.

**Exhibit 1**

<b>Law/Regulation</b>	<b>Concerning</b>
Section 10-1-101-10-1-130	General Provisions
Section 10-2-101-10-2-704	Colorado Single Insurance Producer Licensing Act
Section 10-3-1101-10-3-1104	Unfair Competition – Deceptive Practices
Section 10-8-601-10-8-605	Small Employer Health Insurance Availability Program Act
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-401-10-16-427	Health Maintenance Organizations
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Regulation 1-1-4	Maintenance of Offices in this State
Regulation 1-1-7	Market Conduct Record Retention
Regulation 1-2-10	Colorado Single Producer Act: Conditions, Fees and Transition
Regulation 4-2-3	Sickness and Accident Insurance Advertising
Regulation 4-2-5	Hospital Definition
Regulation 4-2-7	Payment of Monetary Penalties by Commercial Insurance Companies, Nonprofit Hospital and Health Service Corporations, Health Maintenance Organizations and Property and Casualty Insurance Companies for Failure to Promptly Pay Claims for Services
Regulation 4-2-8	Required Health Insurance Benefits for Home Health Services and Hospice Care
Regulation 4-2-11	Individual and Group Health Insurance Rate Filings
Regulation 4-2-12	Concerning Pre-Existing Conditions and Qualifying Previous and Existing Coverages

Regulation 4-2-15	Required Provisions in Carrier Contracts with Providers and Intermediaries Negotiating on Behalf of Providers
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued to Self-employed Business Groups of One
Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-5, (Amended)	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Health Plans
Regulation 4-6-8	Concerning Small Employer Health Plans
Regulation 4-6-8, (Amended)	Concerning Small Employer Health Plans
Regulation 4-6-9	Conversion Coverage
Regulation 4-7-1	Health Maintenance Organizations
Regulation 4-7-2	Health Maintenance Organization Benefit Contracts and Services in Colorado
Regulation 6-2-1	Complaint Record Maintenance
Regulation 6-2-2	Responses to Division Inquiries Regarding Complaints
Regulation 6-2-2, (Amended)	Responses to Division Inquiries Regarding Complaints

**Company Operations/Management**

The examiners reviewed Company management and administrative controls, the Certificate of Authority, Board of Directors meeting minutes, internal/external auditing functions, record retention, provider contracts, and timely cooperation with the examination process.

**Marketing and Sales**

The examiners reviewed all of the material provided, for language that does not accurately represent products or that could be untrue, deceptive or misleading with respect to the offering of small group health benefit plans in Colorado. The Company's website on the Internet contains generic information about Aetna U.S. Healthcare Inc.'s products and services. The solicitation materials for small group health plans were reviewed for compliance with disclosure requirements and the examiners checked for the submission of the Certificate of Compliance which must be filed annually with the Colorado Division of Insurance.

**Complaints**

The examiners reviewed and compared the complaint log maintained by the Division of Insurance against the Company's complaint log to verify the accuracy of the Company's tracking system. In addition, examiners determined if the Company had instituted Complaint Appeal and Grievance procedures. The examiners reviewed the Member Appeal Process and the Appeal/Complaint Resolution Process, evaluated the Company's complaint handling methodology, and reviewed the reason for and disposition of complaints.

**Producers**

The Division of Insurance issued a Stipulation and Order on August 19<sup>th</sup>, 1998, concerning the failure of Aetna U.S. Healthcare Inc., a Colorado corporation and Aetna Life Insurance Company, a Connecticut corporation to appoint licensed insurance producers before accepting risks on insurance products solicited and procured by such producers. Due to the 1998 audit that resulted in this order, the examiners did not review producers during this examination.

**Contract Forms**

For expediency purposes, the examiners requested for review the Schedule of Benefits and the exclusions for the Basic and Standard Plans, and contract forms of the most commonly sold plan, that were issued by the Company and that were certified with the Colorado Division of Insurance (DOI) between January 1, 1998, and December 31, 1998. Examiners recommended to the Company that any violations found in the forms reviewed are to be corrected in all forms that contain the same or similar violations. The Company did not produce the mandated Basic and Standard conversion plan, but produced instead its own conversion plan that it filed in October of 1998. However, since the Company informed the examiners that no conversion plans were sold in 1998, the examiners did not review the Company's conversion plan.

**Rating**

The examiners reviewed ten (10) of the small group files selected from the application review sample. The rates charged to the groups were compared with the rates filed with the Division of Insurance.

**Applications**

For cases that were issued during the period from January 1, 1998, through December 31, 1998, the examiners systematically selected a sample of fifty (50) files, of which three (3) were large National Accounts, and one file could not be provided. This reduced the sample reviewed to forty-six (46) files.

**Cancellations/Non-Renewals/Declinations**

For the period January 1, 1998, through December 31, 1998, the examiners reviewed the entire population of forty-nine (49) cancellation files. The Company stated that it did not decline any small group applications, including business groups of one, during the examination period. The cancellation files were examined for compliance with statutory requirements and contractual obligations. During the examination period, the Company retroactively terminated groups for non-payment of premium, but informed the examiners that it has since changed its procedures to terminate groups at a future date and attempt to collect past due premiums.

**Claims**

Systematically selected samples of 100 paid and 100 denied claims received from January 1, 1998, through December 31, 1998, were reviewed for the Company's overall claims handling practices to determine timeliness of payment and accuracy of processing.

**Utilization Review**

The examiners reviewed the Company's utilization management program including policies and procedures. The examiners also reviewed a systematically selected sample of fifty (50) files requiring utilization review decisions from a population of 1,527 files.

**EXAMINATION REPORT SUMMARY**

The examination resulted in a total of fifty-two (52) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Company Operations/Management:** The examiners found four (4) areas of concern in their review of company operations and management.

1. Failure to establish a mechanism that would allow enrollees the opportunity to participate in matters of policy and operation.
2. Failure to provide enrollees with a statement of financial condition.
3. Failure to specify in provider contracts that the provider is solely responsible for obtaining preauthorization.
4. Failure to accurately reflect the required provisions for continuity of care in provider contracts.

It is recommended that the Company establish, and monitor the necessary procedures to ensure compliance with Colorado insurance law.

- **Marketing and Sales:** The examiners found four (4) areas of concern in their review of marketing and sales materials.

1. Failure to correctly reflect on the Colorado Health Benefit Plan Description Form, the benefits required to be provided under the Colorado Basic and Standard Plans.
2. Failure to timely file an advertising Certificate of Compliance.
3. Failure to disclose on all marketing materials, the existence, availability, and general nature of the Company's access plan.
4. Failure to include the disclosure requirements of Regulation 4-6-8 on all marketing materials.

It is recommended that the Company establish procedures to ensure that its marketing materials comply with Colorado insurance law.

- **Complaints:** The examiners found one (1) area of concern in their review of complaints and the procedures for the handling and processing of complaints.

1. Failure to record on the master complaint log, all written complaints received.

It is recommended that the Company establish procedures to ensure that all complaints received are properly recorded in accordance with Colorado insurance law.

- **Contract Forms:** Examiners found twenty-five (25) areas of concern in their review of the Company's contract forms (employer/employee applications, waiver forms, and evidences of coverage). Examiners identified and summarized the following issues:
  1. Some forms in use during the examination period had not been certified with the Colorado Division of Insurance.
  2. Eligibility for dependents was more restrictive than permitted by law.
  3. Eligibility was conditioned on health status; actively-at-work status; and non-confinement status in some cases.
  4. The Company's utilization review procedures were not accurately disclosed.
  5. The Company reserved the right to retrospectively deny coverage for emergency services.
  6. Some contract forms contained provisions that were more restrictive than, or contrary to, regulatory requirements.
  7. Application forms did not contain some mandatory disclosure statements.
  8. Information concerning services covered under small group plans was misleading or not clearly or accurately disclosed.
  9. The Company allowed for a variable time period in which to notify members of their PCP's termination.
  10. Members were not provided correct information concerning eligibility for conversion, and conversion coverage was more restrictive than permitted by law.

The examiners recommend that the Company review and revise all forms to comply with small group law and regulations, including forms that were not reviewed during the examination process for expediency purpose but which contain similar language. The examiners also recommend that the Company conduct internal reviews, take appropriate action, and report the results of its internal reviews to the Colorado Division of Insurance.

- **Rating:** Examiners identified one (1) area of concern. The examiners compared the Company's rates filed with the Division of Insurance to the rates charged to the members of small groups.
  1. Failure to charge rates as filed.

The examiners recommend that the Company review and revise its procedures to ensure that rates are filed and used according to Colorado law.

- **Applications**: The examiners found eight (8) areas of concern in their review of small group application files for the examination period. The examiners identified the following issues:
  1. Failure to display required disclosure statements on application forms and renewal notices concerning an employer's right to choose between composite and age-banded rates.
  2. Failure to disclose information concerning new and renewal rates and premium impact.
  3. Failure to obtain correct waivers of coverage.
  4. Failure to obtain census data.
  5. Failure to comply with law when using age-banded vs. composite rates for Small Group Employers.
  6. Failure to observe the plan sponsor's right to choose the length of the waiting period.
  7. Failure to correctly state the student dependent age on applications and proposals.
  8. Failure to correctly define an eligible employee.

The examiners recommend that the Company review and revise its applications, forms, and procedures to comply with Colorado small group law and regulations.

- **Cancellations/Non-Renewals/Declinations**: There were three (3) areas of concern identified during the review of the small group cancellation/non-renewal/declination files.
  1. Failure to offer the Basic and Standard Plans upon termination of the group plan or an enrollee's coverage under the group plan, and failure to maintain records of offers.
  2. Failure to maintain cancellation/termination records.
  3. Failure to terminate small group coverage in a consistent manner and consistent with Colorado insurance law.

The examiners recommend that the company review and correct any inadequacies in procedures to ensure that proper termination and conversion information is sent in a consistent and timely manner and that records are complete and properly maintained.

- **Claims**: The examiners found two (2) areas of concern in their review of the claims handling practices of the Company.
  1. Failure to accurately process claims.
  2. Failure to pay claims for eligible services.

The examiners recommend that the Company review its claim processing procedures and quality controls to ensure that they are adequate to minimize or prevent errors from recurring. Additional training or retraining of claims personnel should occur as needed. The additional benefits due on all underpaid claims should be released in a timely manner. All overpayments identified in this review should be waived by the Company.

- **Utilization Review:** The examiners found four (4) areas of concern in their review of Utilization Review procedures.
  1. Failure to provide the notification of decision on first level appeals within the required time frame.
  2. Failure to advise in acknowledgement letters, the correct time frame as allowed by law to make a decision involving a first level appeal.
  3. Failure to include all of the information required by law in the notification of an adverse decision involving first level appeals.
  4. Failure to inform members of their rights as allowed by law in second level appeal letters.

The examiners recommend that the Company review its utilization review policies and procedures to ensure that they are adequate and that they provide for the proper treatment of enrollees and appropriate decision-making in situations requiring review.

**MARKET CONDUCT EXAMINATION REPORT**

**FACTUAL FINDINGS**

**AETNA U.S. HEALTHCARE INC.**

**COMPANY OPERATIONS / MANAGEMENT**  
**FINDINGS**

**Issue A1: Failure to establish a mechanism that would afford enrollees the opportunity to participate in matters of policy and operation.**

Section 10-16-404(2), C.R.S., Governing body, states:

Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

The Company informed examiners that its Member Advisory Committee, whose purpose is to provide an opportunity for enrollees to participate in matters of policy and operations, and to offer insight into how the Plan is perceived and functions from the member standpoint, was not formed until August 17, 1999.

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**Recommendation No. 1:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-404(2), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that the Member Advisory Committee is actively meeting thus allowing enrollees participation as required by law.

**Issue A2: Failure to provide enrollees with a statement of financial condition.**

Section 10-16-407, C.R.S., Information to enrollees, states:

- (1) Every health maintenance organization shall annually provide to its enrollees:
  - (a) The most recent annual statement of financial condition including a balance sheet and summary of receipts and disbursements;
  - (b) A description of the organizational structure and operation of the health care plan and a summary of any material changes since the issuance of the last report;

The Company could not produce a copy of the material supplied to members in 1998.

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**Recommendation No. 2:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-407(1), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that the required information is provided annually to its enrollees.

**Issue A3: Failure to specify in provider contracts that the provider is solely responsible for obtaining preauthorization.**

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, effective July 1, 1997, states:

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

The Company's provider contracts are not in compliance with Colorado law in that they do not contain a provision specifying that the sole responsibility for obtaining preauthorization rests with the provider, not with the member. The law is specific in its requirement that provider contracts contain such a provision.

<u>Contract</u>	<u>Form Number</u>
Facility Agreement	CO/Facility 1.0 (5/97)
Ancillary Services Agreement	CO/Ancillary 1.0 (5/97)
Managed Care Agreement	CO/MCA 1 (5/97)
Primary Care Physician Agreement	CO/PCP 2 (10/98)
Independent Practice Association Agreement	CO/IPA 2 (10/98)
Physician Hospital Organization Agreement	CO/PHO 2 (10/98)
Physician Group Agreement	CO/Physician Group 2 (10/98)
Provider Group Agreement	CO/Provider Group 1.0 (05/97)
Provider Agreement	CO/Provider 1.0 (5/97)
Specialist Physician Agreement	CO/Spec 2 (10/98)

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**Recommendation No. 3:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-705(14), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to specify that preauthorization is the sole responsibility of the provider.

**Issue A4: Failure to accurately reflect in provider contracts the required provisions for continuity of care.**

Section 10-16-102(26.5), C.R.S., Health Care Coverage, Definitions, states:

"Managed care plan" means a policy, contract, certificate, or agreement offered by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services through the covered person's use of health care providers managed by, owned by, *under contract with*, or employed by *the carrier because the carrier either requires the use of or creates incentives, including financial incentives, for the covered person's use of those providers.* [Emphasis added.]

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

- (4)(a) Every contract between a carrier and a participating provider shall include provisions for continuity of care as specified in this subsection (4).
- (c) In the circumstance that coverage is terminated for any reason other than nonpayment of the premium, fraud, or abuse, every managed care plan shall provide for continued care for covered persons being treated at an in-patient facility until the patient is discharged.

The Company's provider contracts are not in compliance with law in that:

1. Provision is not made for continuity of care for a Member who is hospital confined at the time his or her *coverage* terminates while the group contract remains in force; and
2. Provision is made *at the sole discretion of the Company, or at the Company's request*, for continuity of care for a Member whose coverage has terminated because the group contract has terminated if that Member is under active treatment at a facility, until the earlier of the date such treatment is completed or the Company transfers the Member's care to another provider. The examiners note that in the event of insolvency or cessation of operations, the Company (correctly) does *not* reserve such a right to itself.
3. Provision is made for continuity of care at the Member's or Company's request, until the anniversary date of such Member's respective Plan or for one (1) calendar year, whichever is less.

The law requires that continuity of care be provided for a Member who is hospital confined and whose *coverage* terminates:

- A. Regardless of whether or not the group contract remains in force.
- B. *Not* at the Company's sole discretion or only at the Company's request. The Provider remains obligated to provide services until the Member is discharged. However, the Company may retain the right to decide the medical necessity of continued confinement, and to transfer a Member to another facility.

- C. Until the Member's discharge from inpatient care, not the earlier of one (1) year or the anniversary date of the Employer's Plan.

The Company's:

- Facility, Ancillary Provider, Hospital, Provider Group, and Provider contracts state as follows (words that vary between contracts have been placed in brackets by the examiners):

#### 7.0 Term and Termination

7.5 Obligations Following Termination. Following the effective date of any termination [or non-renewal] of this Agreement or [termination of] any Plan, [Facility] [Provider] [Hospital] [Group and Participating Group Providers] shall comply with the following obligations. This section shall supersede any contrary agreements now existing or hereinafter made and shall survive the termination of this Agreement, regardless of the cause of termination.

7.5.1 Upon Termination. Upon termination *of this Agreement* for any reason, other than termination by Company in accordance with Section 7.4 above, [Facility] [Provider] [Hospital] [each Participating Group Provider] shall remain obligated *at Company's sole discretion* to provide [Facility] [Provider] [Hospital] [Covered] Services to: (a) any Member [who is] [under active treatment at Facility] [receiving services from Provider] [an inpatient at Hospital] [under [said Participating Group] Provider's care] [who at the time] [as of the effective date] of termination, [is a registered bed patient at a Participating Facility] until [the Member's course of treatment is completed] [such Member's discharge] [such treatment is completed] or Company's orderly transition of such Member's care to another provider, whichever is less; and (b) any Member, upon request of such Member or the applicable Payor, *until the anniversary date of such Member's respective Plan or for one (1) calendar year, whichever is less.* The terms of this Agreement shall apply to such services. [Emphases added.]

7.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of a Company Affiliate that is an HMO, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this Section, [Facility] [Provider] [Hospital] [Participating Group Providers] shall continue to provide [Facility] [Provider] [Hospital] [Covered] Services: (a) to all Members for the period for which premium has been paid; and (b) [if Facility is an inpatient facility], to Members confined [as inpatients] [in Hospital] [in an inpatient facility] on the date of insolvency or other cessation of operations until medically appropriate discharge. This [provision] [section] shall be construed to be for the benefit of Members. No modification of [to] this provision [section] shall be effective without the prior written approval of the applicable regulatory agencies.

- PCP, IPA, Physician Hospital Organization, Physician Group, and Specialist contracts state:

Term and Termination

7.5 Obligations Following Termination. Following the effective date of any termination or non-renewal of this Agreement, or termination of any Plan, [IPA] [PHO] [Group] and Participating [IPA] [PHO] [Group] Provider[s] shall comply with the following obligations.

7.5.1 Upon Termination. Company [[PHO] [Group] and] [, Participating [PHO] [Group] [Provider[s]]] [and IPA] desire[s] to promote continuity of care. Accordingly, upon termination [or non-renewal] of this Agreement for any reason, other than termination [or non-renewal] by Company in accordance with Section 7.4 above, [each Participating IPA [PHO Professional] [Group] [Provider]] shall remain obligated *at Company's request* to provide Covered Services to: (a) any Member under [said Participating [IPA] [PHO Professional's] [Group]] [Provider's] care who, at the time of the termination or non-renewal, is a registered bed patient at a Participating [Provider that is a hospital or other institution] [Facility] until such Member's discharge therefrom or Company's orderly transition of such Member's care to another provider, whichever is less; and (b) [any Member, upon request of such Member or the applicable Payor,][each Participating PHO Hospital shall remain obligated at Company's discretion to provide Hospital Services to any Member who is an inpatient at said Participating PHO Hospital as of the date of termination or non-renewal until such Member's discharge therefrom or Company's orderly transition of such Member's care to another provider, whichever is less. In

addition, Participating PHO Providers shall, *at Company's request*, remain obligated to provide Covered Services to any Member, upon request of such Member or the applicable Payor,] *until the anniversary date of such Member's respective Plan or for one (1) calendar year, whichever is less*. The terms of this Agreement shall apply to such services. [Emphases added.]

7.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of a Company Affiliate that is an HMO, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this Section, [Participating [IPA] [PHO] [Group]] [Provider[s]] shall continue to provide Covered Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This section shall be construed to be for the benefit of Members. No modification [of] [to] this section shall be effective without the prior written approval of the applicable regulatory agencies.

Contract

Form Number

Facility Agreement	CO/Facility 1.0 (5/97)
Ancillary Services Agreement	CO/Ancillary 1.0 (5/97)
Managed Care Agreement	CO/MCA 1 (5/97)
Provider Group Agreement	CO/Provider Group 1.0 (05/97)
Provider Agreement	CO/Provider 1.0 (5/97)
Primary Care Physician Agreement	CO/PCP 2 (10/98)
Independent Practice Association Agreement	CO/IPA 2 (10/98)
Physician Hospital Organization Agreement	CO/PHO 2 (10/98)
Physician Group Agreement	CO/Physician Group 2 (10/98)
Specialist Physician Agreement	CO/Spec 2 (10/98)

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**Recommendation No. 4:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-705(4), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its provider contracts to accurately reflect the required provisions for continuity of care.

**MARKETING AND SALES  
FINDINGS**

**Issue B1: Failure to correctly reflect on the Colorado Health Benefit Plan Description form, the benefits required to be provided under the Colorado Basic and Standard Plans.**

Regulation 4-2-20, Concerning the Colorado Comprehensive Health Benefit Plan Description Form, promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 10-16-108.5(11)(b), and 10-16-109, C.R.S., states:

IV. Rules

- D. Carriers shall follow the directions for completing the Colorado Health Plan Description Form found in Appendix B of this regulation.
- E. Carriers shall provide a Colorado Health Plan Description Form as follows:
  - 2. Carriers also shall provide automatically, *as part of their marketing materials*, to any potential policyholder to whom a carrier is marketing coverage, either: . . .
- G. *A carrier shall develop a separate Colorado Health Plan Description Form for each of its policies, contracts, and plans of benefits.* If a carrier offers a policy with a choice of copays, coinsurance levels, deductibles, lifetime maximums, annual maximums, and/or other benefit maximums, minimums or restrictions, the carrier shall provide a separate Colorado Health Plan Description Form *specific to the particular benefits of the policy being sold, marketed, or which is in place.*
- H. The Colorado Health Plan Description Form is designed to be a stand-alone piece describing a health benefit plan. The forms should not include attachments, except that a carrier may:
  - 3. Include on the form or as an attachment information that is statutorily required of marketing materials (e.g., for managed care plans, *disclosure of the existence of an access plan*).

[Emphases added.]

Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), and 10-16-108.5(8), C.R.S., Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado, states:

- I. *The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."*

- II. *The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."*
- V. 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 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.*

TABLE 1.	BASIC HMO
3. OUT-OF-POCKET ANNUAL MAXIMUM (includes deductible but <i>not flat dollar copays, except for HMOs</i> )	
Individual	\$2,000
Family	\$4,500
7. MEDICAL OFFICE VISITS (including physician, mid-level practitioner, & specialist visits)	\$20
8. PREVENTIVE CARE	\$10 copay/visit
9. MATERNITY CARE	
Prenatal (deductible does not apply)	\$20 copay/office visit;
10. MENTAL HEALTH	
Outpatient care	50%. HMO pays maximum of greater of 20 visits or \$1,000/ year

11. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY<sup>16</sup> \$20 copay/visit
- <sup>16</sup> Coverage for medically necessary therapeutic treatment only. Benefits will not be paid for maintenance therapy *after maximum medical improvement achieved.*
12. DURABLE MEDICAL EQUIPMENT  
(Maximum \$800/year paid by plan) <sup>17</sup> 50%
- <sup>17</sup> Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. *Home-administered oxygen and prostheses are considered to be items of durable medical equipment.*
13. ORGAN TRANSPLANTS<sup>18</sup> \$300 copay/in-patient day; \$150 copay/outpatient or ambulatory surgery visit
- <sup>18</sup> *Covered transplants include: liver, heart, heart/lung, cornea, kidney, and bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for one marrow transplants. Transplants will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.*
14. HOME HEALTH CARE \$20 copay/visit
15. HOSPICE CARE \$50 copay inpatient hospice per diem; \$20 copay home hospice per diem.
16. OUTPATIENT PRESCRIPTION DRUGS 50% up to maximum of \$30 copay/prescription
- 16A. SKILLED NURSING FACILITY CARE<sup>19</sup> \$50 copay/day

TABLE 2.	STANDARD HMO
3. OUT-OF-POCKET MAXIMUM (includes deductible but not flat dollar copays, except for HMOs)	
Individual	\$2,000
Family	\$4,500
6. OUTPATIENT/AMBULATORY SURGERY	\$10 copay/visit;
7. MEDICAL OFFICE VISITS (including physician, mid-level practitioner, & specialist visits)	\$10 copay/visit;
9. MATERNITY CARE	
Prenatal (deductible does not apply)	\$10/office visit; no copay for procedures, tests ordered by physician
10. MENTAL HEALTH	
Outpatient care	50% [20 visits or \$1,500/year maximum]
11. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	\$10 visit
12. DURABLE MEDICAL EQUIPMENT (Maximum \$800/year paid by plan) <sup>17</sup>	50%

<sup>17</sup> Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. Home-administered oxygen and prostheses are considered to be items of durable medical equipment.

13. ORGAN TRANSPLANTS<sup>18</sup> \$100/admission copay

<sup>18</sup> Covered transplants include: liver, heart, heart/lung, cornea, kidney, and bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for one marrow transplants. Transplants will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.

16. OUTPATIENT PRESCRIPTION DRUGS \$5copay generic; \$10 copay brand name

16A. SKILLED NURSING FACILITY CARE<sup>19</sup> \$50 copay/day

<sup>19</sup> Care must follow a hospital confinement and the skilled nursing facility confinement must be the result of an injury or sickness that was the cause of the hospital confinement. Coverage for medically necessary skilled nursing facility care only. *Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.*

[Emphases added.]

The Company provided the examiners with two copies of the Colorado Health Benefit Plan Description Form in use in 1998.

- The Health Plan Description Form in earlier use in 1998, is not in compliance with the requirements of Colorado law in that the:

1. *Basic Plan* provides:

A. *Out-of-Pocket Maximums* of \$1,500 per individual and \$3,000 per family.

The statutory Basic Plan Out-of-Pocket Maximums are \$2,000 per individual and \$4,500 per family. The Company's form states:

5. ENROLLEE OUT-OF-POCKET  
ANNUAL MAXIMUM<sup>2</sup>

- |               |           |
|---------------|-----------|
| a) Individual | a) \$1500 |
| b) Family     | b) \$3000 |

- B. *Preventive Care*, subject to a \$20 copay for both children's and adults' services. The statutory Basic Plan copay is \$10 for these services. The Company's form states:

9. PREVENTIVE CARE	Primary Copay Applies
a) Children's services	a) \$20 per visit
b) Adults' services	b) \$20 per visit

- C. *Maternity Prenatal Care*, subject to a \$20 copay for the initial visit only. The statutory Basic Plan provides for a \$20 copay *per visit* for prenatal care. The Company's form states:

10. MATERNITY	
a) Prenatal care	a) Specialist Copay Applies \$20 copay for initial visit only
b) Delivery & inpatient well baby care	b) Inpatient Copay Applies \$300 copay per day

- D. *Prescription Drugs*, subject to:

- (a) A copay of 50% AWP; and
- (b) Mail Order Drug program for maintenance drugs subject to a copay of two (2) times the single prescription drug copay for a 90 day supply of a maintenance drug.

The statutory Basic Plan:

- Provides for a copay of 50%, *up to \$30 per prescription*; and
- Does not provide for a reduced copay when prescription drugs are provided through a mail order drug pharmacy. This is an enhancement not permitted under Regulation 4-6-5 other than as a benefit option, which if elected by the contractholder, must be provided by rider.

The Company's form states:

11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	Per Prescription Copay 50% AWP Includes contraceptives. Includes diabetic supplies Maintenance/Mail Order Drug Copay 2 times copay per 90 day supply
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- J. *Organ Transplant* coverage for transplants that are not experimental or investigational. The statutory Basic Plan specifically limits the organ transplant procedures that are covered. It does not provide for coverage of every transplant that is not experimental or investigational. The Company's form states:

24. ORGAN TRANSPLANTS      Non-experimental and non-investigational transplants are covered. Inpatient Copay Applies \$300 copay per day.

- K. *Home Health Care*, not subject to a copay. The statutory Basic Plan copay is \$20 per visit for home health care. The Company's form states:

25. HOME HEALTH CARE      No copay (100% covered)

- L. *Hospice Care*, subject to a copay of \$300 per day for inpatient care and no copay for outpatient care. The statutory Basic Plan copay is \$50 per day for inpatient care and \$20 per visit for outpatient hospice care. The Company's form states:

26. HOSPICE CARE      a. Inpatient—Inpatient Copay Applies \$300 copay per day  
b. Outpatient—No copay (100% covered)

- M. *Skilled Nursing Facility Care*, subject to a copay of \$300 per day. The statutory Basic Plan copay is \$50 per day. The Company's form states:

27. SKILLED NURSING FACILITY CARE      Inpatient Copay Applies \$300 copay per day

2. *Standard Plan* provides:

- A. *Out-of-Pocket Maximums* of no more than 200% of the annual premium. The statutory Standard Plan Out-of-Pocket Maximums are \$2,000 per individual and \$4,500 per family, not to exceed 200% of the premium. The Company's form states:

5. ENROLLEE OUT-OF-POCKET ANNUAL MAXIMUM<sup>2</sup>

a) Individual      a) May not exceed 200% of annual premium  
b) Family      b) May not exceed 200% of annual premium

- B. *Skilled Nursing Facility Care*, limited to 120 days per year. The statutory Standard Plan does not limit skilled nursing facility days, other than by attainment of maximum medical improvement. The Company's form states:

28. SKILLED NURSING FACILITY CARE                      \$50 copay per day, 120 days per year

- The Health Plan Description Form in use later in 1998, is not in compliance with the requirements of Colorado law in that the:

1. *Basic Plan* provides:

- A. *Maternity Prenatal Care*, subject to a \$20 copay for the *initial visit only*. The statutory Basic Plan provides for a \$20 copay *per visit* for prenatal care. The Company's form states:

10. MATERNITY

- |  |   |
|--|---|
| a) Prenatal care                       | a) Specialist \$20 copay for initial visit only |
| b) Delivery & inpatient well baby care | b) Inpatient Hospital Copay: \$300 per day      |

- B. *Urgent, non-routine, after hours care*, subject to a copay of \$25 when services are provided by the PCP. The PCP copay is \$20 under the statutory Basic Plan, regardless of whether the visit is during or after office hours. The Company's form states:

17. URGENT, NON-ROUTINE, AFTER HOURS CARE      a) After Hours PCP visit - \$25 per visit copay  
b) Emergency Room - \$200 copay per visit, Waived if admitted.

- C. *Mental Health Care* on an outpatient basis (other than for outpatient biologically-based mental illness care), subject to a 20 visit maximum per calendar year. The statutory Basic Plan provides that the benefit be limited to the greater of 20 visits and \$1,000 per calendar year. The Company's form states:

19. OTHER MENTAL HEALTH CARE

- |                    |  |
|--------------------|--|
| a) Inpatient care  | a) Inpatient – 50% copay. 45 days per year maximum, or 90 days partial confinement per year. |
| b) Outpatient care | b) Outpatient – 50% copay, 20 visits per year maximum.                                       |

D. *Oxygen* coverage at 100%. The statutory Basic Plan provides for oxygen to be considered part of the durable medical equipment benefit, and therefore subject to the \$800 calendar year maximum for such equipment. The Company's form states:

23. OXYGEN	No copay (100% covered)
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E. *Organ Transplant* coverage for transplants that are medically necessary. The statutory Basic Plan specifically limits the organ transplant procedures that are covered. It does not provide for coverage of every transplant that is medically necessary. The Company's form states:

24. ORGAN TRANSPLANTS	\$300 copay per inpatient day. Medically necessary transplants are covered.
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2. *Standard Plan* provides:

A. *Routine Medical Office Visits*, subject to a copay of \$15. The statutory Standard Plan copay for medical office visits is \$10 per visit. The Company's form states:

8. ROUTINE MEDICAL OFFICE VISITS	Primary Care: \$15 per visit copay Specialists : \$15 per visit copay.
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B. *Maternity Prenatal Care*, subject to a \$20 copay for the *initial visit only*. The statutory Standard Plan provides for a \$20 copay *per visit* for prenatal care. The Company's form states:

10. MATERNITY

- |  |  |
|--|--|
| a) Prenatal care                       | a) Specialist \$10 copay for initial visit only  |
| b) Delivery & inpatient well baby care | b) Inpatient Hospital Copay: \$100 per admission |

- C. *Prescription Drugs*, subject to copays of \$10 and \$20 for generic and brand name drugs respectively. The statutory Standard Plan provides for copays of \$5 and \$10 respectively. The Company's form states:

11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	Generic Prescription Drug Copay \$10 Brand Prescription Drug copay \$20 Includes oral contraceptives Diabetic supplies included.
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- D. *Outpatient Ambulatory Surgery*, subject to a copay of \$50 per visit. The statutory Standard Plan provides for a copay of \$10 for outpatient surgery. The Company's form states:

13. OUTPATIENT AMBULATORY SURGERY	\$50 per visit.
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- E. *Urgent, non-routine, after hours care*, subject to a copay of \$20 per visit for PCP services. The statutory Standard Plan provides for PCP visits to be subject to a copay of \$10, regardless of when provided. The Company's form states:

17. URGENT, NON-ROUTINE, AFTER HOURS CARE	a) After Hours PCP Visit - \$20 per visit copay b) Emergency Room - \$50 copay per visit, waived if admitted.
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- F. *Mental Health Care* (other than for biologically-based mental illness care), to be subject to a maximum of 20 visits. The statutory Standard Plan provides for outpatient mental illness visits to be limited to the greater of 20 visits and \$1,500. The Company's form states:

19. OTHER MENTAL HEALTH CARE	a) Inpatient – 50% copay. 45 days per year maximum, or 90 days partial confinement per year b) Outpatient care
	b) Outpatient – 50% copay, 20 visits per year.

- G. *Physical, Speech, and Occupational Therapy* copay of \$15. The statutory Standard Plan covers therapeutic treatment at a copay of \$10 per visit. The Company's form states:

21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	a) Outpatient—\$15 copay per visit. b) Inpatient—No copay, 100% covered. Coverage for medically necessary therapeutic treatment only. No benefits for maintenance therapy.
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**Issue B2: Failure to timely file a Certificate of Compliance.**

Section 10-3-109(1), C.R.S., Reports, statements, and maintenance of records - publication - penalties for late filing or failure to maintain, in part states:

Every insurance company doing business in this state, on or before the first day of March in each year, shall render to the commissioner a report, signed and sworn to by its chief officers, of its condition on the preceding thirty-first day of December, which shall include . . .

Regulation 4-2-3(III)(C)(3), Sickness and Accident Insurance Advertising, Definitions, promulgated under the authority of Section 10-1-109, C.R.S., defines “insurer”:

"Insurer" shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, . . .

Regulation 4-2-3(III)(R), Sickness and Accident Insurance Advertising, Certificate of Compliance, promulgated under the authority of Section 10-1-109, C.R.S., states:

Each insurer required to file an Annual Statement, which is now or which hereafter becomes subject to the provisions of this regulation, must file with this Division, with its Annual Statement, a Certificate of Compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of this regulation rules and the Insurance Laws of this State as implemented and interpreted by this regulation.

The Company provided the examiners with copies of the Certificate of Compliance for years ended December 31, 1998, and December 31, 1997. These had been filed on October 4, 1999, after the March 1, due dates.

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**Recommendation No. 6:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-109(1), C.R.S., and Regulation 4-2-3(III)(R). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that the Company’s Certificate of Compliance is filed henceforth in a timely manner.

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**Issue B3: Failure to disclose on all marketing materials, the existence, availability, and general nature of the Company's access plan.**

Section 10-16-704(9), C.R.S., Network adequacy, states:

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. [Emphasis added.] . . .

Regulation 4-6-8(9), Concerning Small Employer Health Plans, Disclosure requirements, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), 10-16-105(5), 10-16-105(7.3)(d.5) (III), 10-16-108.5 (8), 10-16-109, and 10-16-214(1)(d), C.R.S., states:

(A) Pursuant to Section 10-16-105(5), as amended by Senate Bill 97-54, and 10-16-704(9), C.R.S., small employer carriers shall provide, *on all printed marketing and solicitation materials* for their small group health products and *in a separate boxed section with bold type no less than twelve (12) point, a clearly written disclosure that:*

(6) In the case of a managed care plan, on and after January 1, 1998, *explains the existence, availability and general nature of an access plan, (e.g., that an access plan exists for every managed care plan and that it lists hospitals, providers, referral procedures, grievance procedures and emergency coverage provisions).*

[Emphases added.]

The Company's marketing materials were not in compliance with the requirements of Colorado law during 1998 in that they did not disclose the existence, availability, and general nature of the Company's access plan. The Company states that it did not print state specific marketing materials until 1999, at which time it included reference to the access plan in its HMO marketing materials for Colorado. The examiners note that the Company did include a statement referring to the access plan in what appears to be eight (8) point type on the inside back cover of the 1999 marketing materials as part of a general disclosure. The Company also subsequently provided a copy of a notice dated February of 1999, that it stated was a revision of a notice initially in use as of May 1998. While the Company's 1999 marketing materials are not within the scope of the current examination, the examiners note that:

1. The *Disclosure* does not comply with the requirements of law that it:

- Be in a separate boxed section in twelve (12) point type; or
- Explain that the access plan lists hospitals, providers, referral procedures, grievance procedures and emergency coverage provisions.

The 1999 marketing materials Disclosure simply states:

. . . An Access Plan is available for network-based plans. . . .

2. The *Notice* does appear to be in 12 point or larger type but does not comply with the requirement of law that it explain that the access plan lists hospitals, providers, referral procedures, grievance procedures and emergency coverage provisions. The 1999 Notice states:

Notice: Benefit Information

Colorado law requires carriers to make available an Access Plan and a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

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**Recommendation No. 7:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704(9), C.R.S., and Regulation 4-6-8(9). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all marketing materials to correctly disclose the existence, availability, and general nature of the Company's access plan.

**Issue B4: Failure to include the disclosure requirements of Regulation 4-6-8 on all marketing materials.**

Section 10-16-105(5), C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

Each small group sickness and accident insurer or other entity shall make reasonable disclosure in solicitation and sales materials provided to small employers the following information in a form and manner prescribed by the commissioner and upon request of any such small employer shall provide such information in detail:

- (a) The extent to which premium rates for a specific employer are established or adjusted due to the experience, health status, or duration of coverage of employees or dependents of the small employer;
- (b) The provisions concerning the insurer's or other entity's right to, and the frequency with which the insurer or other entity may, change premium rates and the factors, including case characteristics, which affect changes in premium rates;
- (c) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans;
- (d) The provisions relating to renewability of coverage;
- (e) The provisions of such coverage relating to any preexisting condition exclusion; and;
- (f) The benefits and premiums available under all health benefit plans for which the employer is qualified.

Regulation 4-6-8(9), Concerning Small Employer Health Plans, Disclosure requirements, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), 10-16-105(5), 10-16-105(7.3)(d.5) (III), 10-16-108.5 (8), 10-16-109, and 10-16-214(1)(d), C.R.S., states:

- A. Pursuant to Section 10-16-105(5), as amended by Senate Bill 97-54, and 10-16-704(9), C.R.S., small employer carriers shall provide, on all printed marketing and solicitation materials for their small group health products and in a separate boxed section with bold type no less than twelve (12) point, a clearly written disclosure that:
  - (1) Identifies the class of business; Specifies case characteristics and rating factors used in setting new and renewal rates and the extent to which they impact premiums;
  - (3) Explains the employer's right to renew;
  - (4) Explains pre-existing condition exclusions;

- (5) Discloses that rates for any and all small group products being marketed by the carrier in the Colorado small group market will be given to a small employer, upon either oral or written request of such employer, within five (5) working days of the request; and . . .
- B. Small employer carriers also shall include in all printed marketing and solicitation materials information as to the benefits and premiums available under all health benefit plans for which the employer is qualified, pursuant to Section 10-16-105(5), C.R.S., as amended by Senate Bill 97-54. This requirement shall be satisfied if the carrier provides the following information:
- (1) The policy number (if any), policy name and policy type (e.g., HMO, indemnity, point of service plan) for all the plans for which the employer qualifies; and
  - (2) A summary of the benefits available under all the plans for which the employer qualifies which highlights the most salient differences among the plans.

The Company has not included in its marketing materials, the disclosure requirements of Regulation 4-6-8. The required disclosures were not found in any of the small employer marketing materials provided by the Company for review by the examiners.

**Recommendation No. 8:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105(5), C.R.S., Regulation 4-6-8(9). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all marketing materials to reflect the disclosure requirements of Regulation 4-6-8.

**COMPLAINT  
FINDINGS**

**Issue C1: Failure to record on the Company's master complaint log, all complaints received.**

Section 10-3-1104(1)(i), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

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. The 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.

Regulation 6-2-1(III), Complaint record maintenance, Content of Complaint Record, promulgated pursuant to Section 10-3-1110, C.R.S., states:

*Attachment A of this Regulation sets forth the minimum information required [emphasis added] to be contained in a person's complaint record in order for it to comply with the statute. Refinements and additions to the information specified therein may, of course, be maintained in such complaint record. Attachment B of this Regulation contains an explanation of the various headings, codes and other notations contained in Attachment A. The codes are used in order to simplify both the identification of the action underlying the complaint and the keeping of the records.*

Attachment A

Column  
G

Insurance  
Department  
Complaint

The Company did not record all complaints, appeals and grievances received during the examination period on its Company Complaint Log. The Company provided examiners with copies of thirty-four (34) written complaints received during the examination period. Ten (10) of these complaints, which included all four (4) Division of Insurance Complaints, were not recorded on the Company's master complaint log.

**Recommendation No. 9:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104(1), and Regulation 6-2-1(III). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its complaint handling procedures to ensure that all written complaints, appeals and grievances are recorded in the Company's complaint log.

**UNDERWRITING  
CONTRACT FORM  
FINDINGS**

**Issue E1: Failure to provide correct information on enrollment materials concerning coverage of prescription drugs under a converted contract, and failure to provide for conversion of prescription drug coverage.**

Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado, promulgated pursuant to Sections 10-1-109, C.R.S., 10-16-105(7.2), C.R.S., and 10-16-108.5(8), C.R.S., states:

TABLE 1.	BASIC HMO
16. OUTPATIENT PRESCRIPTION DRUGS	50% up to maximum of \$30 copay/ prescription
TABLE 2.	STANDARD HMO
16. OUTPATIENT PRESCRIPTION DRUGS	\$5 copay generic; \$10 copay brand name

Regulation 4-6-9(5), Concerning Conversion Coverage, Choice of basic or standard health benefit plans, promulgated under the authority of Sections 10-1-109(1) and 10-16-109, C.R.S., states:

- A. All persons entitled to elect conversion coverage pursuant to Section 10-16-108(4), C.R.S., *shall be offered a choice of the basic or standard health benefit plans only* [emphasis added], except that, pursuant to Section 10-16-108(4) (b), C.R.S., a small employer carrier may offer as conversion coverage the basic health benefit plan only (instead of a choice of the basic or the standard health benefit plan) if all the following conditions are met: . .
- B. All persons entitled to elect conversion coverage pursuant to Section 10-16-108(4), C.R.S., shall be offered a choice of the basic or standard health benefit plans only, except that, pursuant to Section 10-16-108(4) (b), C.R.S., a small employer carrier may offer as conversion coverage the basic health benefit plan only (instead of a choice of the basic or the standard health benefit plan) if all the following conditions are met: . . .
- D. Carriers shall not offer other conversion coverage policies either in addition to or in lieu of the basic and standard health benefit plans. Conversion coverage under the basic and standard health benefits plans *shall not be modified in any way* [emphasis added], . . .

The Company is not in compliance with Colorado law concerning conversion coverage of prescription drugs in that:

1. The Company's Enrollment/Change Request form states that prescription drug benefits are not convertible. Only the Basic and Standard Plans may be offered as conversion coverage in Colorado. Both of these plans include prescription drug coverage. An enrollee converting from a Basic or Standard Plan would have the same prescription drug coverage after conversion that he or she had prior to conversion, while an enrollee converting from another of the Company's plans would have prescription drug coverage:

- That differs from the prior coverage; or
- Even if it was not provided in the plan prior to conversion.

By stating that prescription drug coverage is not convertible, the Company may discourage an enrollee from applying for needed conversion coverage.

The Company's Enrollment/Change Request forms state:

8. Withdrawal From Plan

Individual Conversion – Bill me at home  
(prescription and dental benefits are not convertible)

2. The Company's Prescription Drug Riders denies prescription drug coverage as a benefit under a converted contract. Since only the Basic and Standard Plans may be sold as conversion coverage and prescription drug coverage is an integral component of the Basic and Standard Plans, this benefit cannot be separated from these plans by provision via rider, amendment, or endorsement.

The Company's prescription drug riders state:

Section D of the Continuation and Conversion section of the Certificate is hereby amended to include the following provision:

The conversion privilege does not apply to the HMO Prescription Plan.

<u>Form</u>	<u>Form Number</u>
Prescription Plan Rider	HMO/CO RIDER-RX-1 03/97
Prescription Plan Rider	HMO/CO RIDER-RX-2 05/98
Enrollment/Change Request Form	GR-67603-1 West Central
HMO	(Colorado) (8-98)

**Recommendation No. 10:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulations 4-6-5, and 4-6-9(5). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all forms that incorrectly inform the member of and deny coverage of prescription benefits under a converted contract.

**Issue E2: Failure to provide correct information in contract materials, concerning the eligibility of dependents.**

Section 10-16-102(14), C.R.S., Definitions, states:

“Dependent” means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

Section 10-16-105(7.5)(a), C.R.S., Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans, states:

Effective January 1, 1995, if a small employer carrier offers coverage to a small employer, such small employer carrier shall offer the same coverage to all of the eligible employees of the small employer *and their dependents*. [Emphasis added.] A small employer carrier shall not offer coverage to only certain eligible individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in section 10-16-118(1)(c).

Regulation 4-6-8(5), Concerning Small Employer Health Plans, Requirement to insure entire groups, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214(1)(d), and 10-16-708, C.R.S., states:

A. Covering the entire group

- (1) A small employer carrier that offers coverage to or covers a small employer on a plan of health benefits in effect on or after January 1, 1995, that was issued or renewed on or after July 1, 1994, shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. The small employer carrier shall provide the same health benefit plan under the same terms and conditions to each such employee and dependent. . . .

The Company’s definition of an eligible dependent is more restrictive than permitted by law in that its forms provide for:

1. *A Handicapped child* to be:

- A. Chiefly dependent upon the Subscriber for support and maintenance; and
- B. Incapable of self-support due to mental or physical incapacity; and
- C. Incapacitated prior to the age the child lost eligibility.

Colorado law does not require that a disabled child be:

- Chiefly dependent upon the Subscriber for support and maintenance;
  - Incapable of self-support. A disabled child may be able to work in self-sustaining employment but nevertheless be dependent upon the parent. Only *dependency* is a condition of coverage for disabled dependents;
  - Incapacitated prior to the age the child lost eligibility.
2. *Dependents to be excluded from coverage.* The law requires that Dependents be offered coverage.
  3. Dependent student eligibility to end at age 23.

Colorado law requires dependent students to be covered to age 24.

The Schedule of Benefits that was provided to the examiners included the following variable items:

Dependent Eligibility: [A dependent unmarried child as described in the Eligibility and Enrollment section of the Certificate who is:

- ii. under [19, 20, 21, 22, 23, 24, 25, 26, 30] years of age, dependent on a parent or guardian Member, and attending a recognized college or university, trade or secondary school on a full-time [and part-time] basis, and will be covered [until the end of the month][until the next billing period] [until the end of the year] after they have reached the age specified above; or

The examiners requested copies of ten issued contracts. Two of the contracts provided were 1999 contracts. Upon review of the Schedule of Benefits for the remaining eight Certificates of Coverage (formfooter HMO/CO COC-1 03/97), the variable that appeared in the Schedule of Benefits was the age limit of 23 for students. During the review of the application files, the examiners also found this incorrectly stated age on proposal forms and application forms.

The Company's:

- Certificate of Coverage states:

Eligibility and Enrollment

4. Special Rules Which Apply to Children.
  - b. Handicapped Children.

Coverage is available for a child who is *chiefly dependent upon the Subscriber for support and maintenance*, and who is 19 years of age or older but *incapable of self-support due to mental or physical incapacity*. The incapacity *must have commenced prior to the age the dependent lost eligibility*. [Emphases added.]

- Schedules of Benefits (non Basic and Standard) provide the following in their variable definition of Dependent Eligibility:

Dependent Eligibility:

[A dependent unmarried child as described in the Eligibility and Enrollment section of the Certificate who is:

- iii. *chiefly dependent* upon the Subscriber for support and maintenance, and is 19 years of age or older but *incapable of self-support due to mental or physical incapacity, either of which commenced prior to:* [19, 20, 21, 22, 23, 24, 25, 26], or if a student, [19, 20, 21, 22, 23, 24, 25, 25, 30].]  
[Emphases added.]

[The Group Agreement and Certificate *do not provide coverage for dependents.*  
[Emphasis added.] All references to “dependent” are hereby deleted.]

- Schedules of Benefits (Basic and Standard) provide the following in their definition of Dependent Eligibility:

Dependent Eligibility:

A dependent unmarried child (includes natural, foster, step, legally adopted children and proposed adoptive children) who is:

- iii. a dependent unmarried child (includes natural, foster, step, legally adopted children and proposed adoptive children) who is chiefly dependent upon the Subscriber for support and maintenance, and is 19 years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to: 19, or if a student 24.

- Schedules of Benefits (non Basic and Standard) provide the following in their definition of student eligibility:

Dependent Eligibility:

A dependent unmarried child as described in the Eligibility and Enrollment section of the Certificate who is:

- ii. *under 23 years of age* [emphasis added], dependent on a parent or guardian Member, and attending a recognized college or university, trade or secondary school on a full-time basis and will be covered the end of billing month after they have reached the age specified above; or . . . .

<u>Contract</u>	<u>Form Number</u>
Certificate of Coverage	HMO/CO COC-1 03/97
Certificate of Coverage	HMO/CO COC-2 05/98
Certificate of Coverage	HMO/CO COC-3 10/98
Schedule of Benefits	HMO/CO SB-1 03/97
Schedule of Benefits	HMO/CO SB-2 05/98
Schedule of Benefits	HMO/CO SGBAS/SOB -1 04/97
Schedule of Benefits	HMO/CO SGSTD/SOB -1 04/97

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**Recommendation No. 11:**

Within 30 days the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105(7.5)(a), C.R.S. and Regulation 4-6-8(5). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all contract materials to accurately reflect dependent eligibility. The Company should work with the Division of Insurance to ensure that no dependent was harmed because of this restriction.

**Issue E3: Failure to exclude actively-at-work status and non-confinement status as conditions for eligibility of enrollees.**

Section 10-16-102(15), C.R.S., Definitions, states:

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

Section 10-16-105(7.5), C.R.S., Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans, states:

- (a) Effective January 1, 1995, if a small employer carrier offers coverage to a small employer, such small employer carrier shall offer *the same coverage to all of the eligible employees of the small employer and their dependents*. [Emphasis added.] A small employer carrier shall not offer coverage to only certain eligible individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in section 10-16-118(1)(c).

Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), and 10-16-108.5(8), C.R.S., states:

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

D. Eligibility – “*Actively at work*” and “*non-confinement*” provisions are prohibited. [Emphasis added.]

Regulation 4-6-8(5), Concerning Small Employer Health Plans, Issuance of Coverage, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214(1)(d), and 10-16-708, C.R.S., states

- B. Determining Who is an Eligible Employee, Dependent

The Division finds that, subject to other statutory restrictions and the provisions of this regulation, a small employer carrier may offer a plan of health benefits to the eligible employees of a small employer as that employer defines its eligible employees (hereinafter referred to as "employer-determined eligible employees"). However, the initial offering made to all small employers by a small employer carrier shall be for coverage of all employees with a regular work week of at least 24 hours. The decision of a

small employer to limit eligibility for coverage as provided for in subparagraph (1) of this subsection B shall be solely at the small employer's discretion, without direct or indirect pressure or suggestion by the carrier, producer, or their representatives. The small employer carrier may offer coverage only to such employer-determined eligible employees and their dependents and may apply its minimum participation and contribution criteria solely to such employer-determined eligible employees.

The Company's forms are not in compliance with law in that they provide for:

1. Exclusion of coverage for an employee and his or her dependents if the employee is not actively-at-work on the date (s)he is eligible until such time as (s)he has returned to work for one full day.

The Company provided the examiners with "Colorado Member Bulletin No. 1 for 1999." That Bulletin, effective in 1999, deletes the Actively-at-Work provision which was no longer permitted by law as of January 1, 1995. The examiners note that the Certificate of Coverage as revised effective October 1998, no longer contained the Actively-at-Work requirement, although that edition retained both the definition of "Actively-at-Work" and the exclusion of coverage for confined dependents.

2. Exclusion of coverage for a Dependent who is hospital or elsewhere confined as a result of, or for treatment of, an illness or injury, until he or she is no longer so confined.

The Company's:

- Certificates of Coverage provide:

A. The following variable items:

C. Effective Date of Coverage

[[2.] Actively at Work.

If a Subscriber is not *Actively at Work* [emphasis added] on the date coverage would otherwise become effective, coverage for the eligible individual and any eligible dependents will not become effective until the date the eligible individual is Actively at Work for one full day.]

[[3.] Non-Confinement Rule.

If on the date coverage would otherwise become effective, a dependent [or retired employee] *is confined in a Hospital, at home, or elsewhere, as a result of, or for treatment of, an illness or injury* [emphasis added] on the date coverage would otherwise become effective, coverage will be deferred for that person until such

person has been free of confinement for 31 days after final discharge.]

The Company presented ten (10) Certificates of Coverage actually issued to small groups during the examination period for review. All ten (10) had the above wording in the Effective Date of Coverage Section.

B. The following definition:

Actively at Work. The condition where an employee is performing all of the Subscriber's regular duties for the Contract Holder (the Subscriber's employer) on a regularly scheduled work day, at the location where such duties are normally performed, and on a full-time basis. An employee will be considered to be Actively at Work on a non-scheduled work day only if such person is Actively at Work on the last regularly scheduled work day immediately preceding such non-scheduled work day.

The examiners also found the actively at work requirement on application forms during the review of the application files.

<u>Contract</u>	<u>Form Number</u>
Certificate of Coverage	HMO/CO COC-1 03/97
Certificate of Coverage	HMO/CO COC-2 05/98
Certificate of Coverage	HMO/CO COC-3 10/98

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**Recommendation No. 12:**

Within 30 days the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-105(7.5) and Regulations 4-6-5 and 4-6-8(5). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all contracts and solicitation materials that restrict the eligibility of enrollees based on actively-at-work status and non-confinement status requirements.

**Issue E4: Failure to correctly reflect the benefits required to be provided under the Colorado Basic and Standard Plans.**

Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), and 10-16-108.5(8), C.R.S., Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado, states:

- I. *The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."*
- II. *The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."*
- V. All basic and standard health benefit plans shall also comply with the following requirements:
  - C. Family Planning Services – Family planning services must be included as a covered benefit under both the standard and basic health benefit plans. At a minimum, family planning services shall include maternity care, prenatal and postnatal care and counseling, treatment and screening as appropriate for sexually transmitted diseases, sterilization, contraceptives, and contraception counseling.<sup>1</sup>

<sup>1</sup>Infertility treatment and counseling, and abortion services shall be covered by a carrier under the basic and standard health benefit plans if such services are covered by the carrier under its most frequently sold non-basic, non-standard group health plan in Colorado.

TABLE 1.	BASIC HMO
8. PREVENTIVE CARE	\$10 copay/visit
10. MENTAL HEALTH: [NOTE: Does NOT include treatment for schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder, and panic disorder. These six (6) illnesses are covered as any other physical sickness].	
12. DURABLE MEDICAL EQUIPMENT (Maximum \$800/year paid by plan) <sup>17</sup>	50%

<sup>17</sup>Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. *Home-administered oxygen and prostheses are considered to be items of durable medical equipment.*

14. HOME HEALTH CARE	\$20 copay/visit
16A.SKILLED NURSING FACILITY CARE <sup>19</sup>	\$50 copay/day
TABLE 2.	STANDARD HMO
5. INPATIENT	\$100 copay/ admission
10. MATERNITY CARE	
Delivery and inpatient well baby care <sup>4a</sup>	\$100 copay/admission
10. MENTAL HEALTH: [NOTE: Does NOT include treatment for schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder, and panic disorder. These six (6) illnesses are covered as any other physical sickness].	
12. DURABLE MEDICAL EQUIPMENT (Maximum \$800/year paid by plan) <sup>17</sup>	50%

<sup>17</sup> Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. *Home-administered oxygen and prostheses are considered to be items of durable medical equipment.*

The Company’s Basic and Standard Plan Schedules are not in compliance with the requirements of Colorado law in that the:

1. *Basic Plan Schedule* covers:

B. *Immunizations*, subject to a \$20 copay. Immunizations are part of the Preventive Care benefit and as such are subject to the statutory Basic Plan preventive care copay of \$10. The Company’s Schedule states:

Primary Care Physician Office Visit

Well Child Care Immunizations	\$20 per visit
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B. *Family Planning Services*, at 50% of the contracted rate. Family Planning services are specific services under the basic and standard plans and are subject to the copayments specified for those services.. The Company’s Schedule states:

Family Planning Services	50% (of the contracted rate)
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C. *Mental Health Services* at the levels required by law but does not specify that schizophrenia,

schizoaffective disorders, bipolar affective disorders, major depressive disorders, obsessive-compulsive disorders, and panic disorders are covered the same as any other physical sickness. The Company's Schedule states:

Outpatient Benefits

<u>Benefit</u>	<u>Copayment</u>
Outpatient Mental Health Visits 20 visits or, if greater, \$1,000 per calendar year	50% (of the contracted rate)

Inpatient Benefits

<u>Benefit</u>	<u>Copayment</u>
Mental Health Maximum of 45 days per calendar year	50% (of the contracted rate)

2. *Standard Plan Schedule* covers:

- A. *Inpatient Confinement* at a copayment of \$100 *per day*. The statutory Standard Plan covers inpatient confinement at \$100 *per admission*. The Company's Schedule states:

Inpatient Benefits

<u>Benefit</u>	<u>Copayment</u>
Acute Care Coverage for all physician, surgical And other services delivered during a hospital stay for acute care, including organ transplants.	\$100 per day for each day of confinement
Maternity Delivery and Well Baby Care	\$100 per day for each Day of confinement

- B. *Mental Health Services* at the levels required by law, but does not specify that schizophrenia, schizoaffective disorders, bipolar affective disorders, major depressive disorders, obsessive-compulsive disorders, and panic disorders are covered the same as any other physical sickness. The Company's Schedule states:

Outpatient Benefits

<u>Benefit</u>	<u>Copayment</u>
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Outpatient Mental Health Visits 20 visits or, if greater, \$1,500 per calendar year	50% (of the contracted rate)
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Inpatient Benefits

<u>Benefit</u>	<u>Copayment</u>
Mental Health Maximum of 45 days per calendar year	50% (of the contracted rate)

3. *Basic and Standard Plan Schedules cover Durable Medical Equipment:*

- A. Subject to a *family* maximum of \$800. Per statutory requirements, the maximum amount payable by the Company is \$800 *per enrollee* per year.
- B. Including *prostheses*. The Company's Schedule does not state that prostheses are covered as items of durable medical equipment. The examiners note that the Company provides for the coverage of prostheses in the Certificate of Coverage. However, without a statement concerning the percentage and maximum benefit for the coverage, the enrollee would be led to believe that prostheses are covered at 100% of the cost of the service. This is an enhancement not permitted by law.

The Company's Schedules state:

Durable Medical Equipment Maximum: \$800 per family, per calendar year	50% (of the contracted rate)
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Coverage for lesser of purchase or rental price for medically necessary durable medical equipment, including home-administered oxygen.

<u>Form</u>	<u>Form Number</u>
Basic Plan Schedule	HMO/CO-SGBAS/SOB-1 (4/97)
Standard Plan Schedule	HMO/CO-SGSTD/SOB-1 (4/97)

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**Recommendation No. 13:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Basic and Standard Plan forms to comply with law.

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**Issue E5: Failure to provide for coverage of emergency services unless the Company retrospectively determines that an emergency existed.**

Section 10-16-407(2), C.R.S., Information to enrollees, states:

Every health maintenance organization shall clearly state in its brochures, contracts, policy manuals, and printed materials distributed to enrollees that such enrollees shall have the option of calling the local prehospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent whenever an enrollee is confronted with a life or limb threatening emergency. For the purposes of this section, a “life or limb threatening emergency” means *any event which the enrollee believes* [emphasis added] threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. No enrollee shall in any way be discouraged from using the local prehospital emergency medical service system, the 9-1-1 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such use in a life or limb threatening emergency.

Regulation 4-2-17(VI), Prompt Investigation of Health Plan Claims Involving Utilization Review, Procedures for review decisions, promulgated pursuant to Sections 10-1-109, 10-3-1107, 10-3-1110, and 10-16-109, C.R.S., states:

- G.1. A health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist *if a prudent lay person* having average knowledge of health services and medicine and *acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.* [Emphases added.] Under these same circumstances, a claim for emergency services necessary to screen and stabilize a covered person shall not be denied for failure by the covered person or the emergency service provider to secure prior authorization. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider.
2. *Health maintenance organizations shall also comply with the life or limb threatening emergency coverage provisions of Section 10-16-407(2), C.R.S., in reviewing claims for emergency services necessary to screen and stabilize a covered person.* [Emphasis added.]

The Company's forms are not in compliance with Colorado law in that they provide for retrospective review of emergency services and denial of coverage if the Company later determines that a situation was not an emergency. The decision as to whether an emergency exists rests with the enrollee.

The Company may not retrospectively deny coverage for emergency services if the enrollee reasonably believed that the situation threatened his or her life or limb.

The Company's Certificates of Coverage:

1. Dated March 1997, states:

Covered Benefits

K. Emergency Care/Urgent Care Benefits.

1. A Member is covered for Emergency Services, provided the service is a Covered Benefit, and *HMO's medical review* [emphasis added] determines that the Member's symptoms were severe, occurred suddenly, and immediate medical attention was sought by Member.

Definitions

- Medical Emergency. The sudden and, at that time, unexpected onset of a change in a Member's physical or mental condition which, in the absence of immediate treatment, could, *as determined by HMO* [emphasis added], reasonably be expected to result in loss of life or limb, or significant impairment to bodily function, or permanent dysfunction of a body part. Some examples of Medical Emergencies include heart attacks, convulsions, serious burns, poisoning, and loss of consciousness.

2. Dated May 1998 and October 1998, state:

Covered Benefits

- K. A Member is covered for Emergency Services, provided the service is a Covered Benefit, and *HMO's review* [emphasis added] determines that a Medical Emergency existed at the time medical attention was sought by the Member.

Definitions

- Medical Emergency. The existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or,

with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

<u>Contract</u>	<u>Form Number</u>
Certificate of Coverage	HMO/CO COC-1 03/97
Certificate of Coverage	HMO/CO COC-2 05/98
Certificate of Coverage	HMO/CO COC-3 10/98

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**Recommendation No. 14:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-407(2), C.R.S., and Regulation 4-2-17(VI). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all forms to provide benefit information regarding the coverage of emergency services in an emergency situation as defined by law.

**Issue E6: Failure to limit reasons for termination of state continuation coverage to those permitted by law.**

Section 10-16-108(2), C.R.S., Conversion and continuation privileges, states:

Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.

(a) Every group contract or group service contract providing hospital services, medical-surgical services, or other health services for subscribers or enrollees and their dependents issued by a nonprofit hospital, medical-surgical, and health service corporation or a health maintenance organization operating with a certificate of authority pursuant to part 3 or 4 of this article shall contain a provision which permits every covered employee or enrollee of an employed group whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for such employee and the employee's dependents. Such provision shall conform to the requirements, where applicable, of paragraphs (b), (c), and (d) of this subsection (2).

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

The Company's forms are not in compliance with Colorado law in that they provide for termination of state continuation coverage when the Member:

1. Becomes eligible for Medicare. The law does not provide for termination of coverage when the Member becomes eligible for Medicare. Medicare is not considered to be group coverage.
2. Becomes covered by another group plan. The law provides for termination of coverage in such circumstances, but only if the other group coverage does not exclude a condition covered under the continued plan.

The Company's Certificates of Coverage state:

Continuation and Conversion

B. Continuation of Coverage under Colorado State Law

Continuation under this provision will end on the earlier of:

2. The date the Member becomes eligible for Medicare, Title XVIII of the federal “Social Security Act”, or Medicare [sic], Title XIX of the federal “Social Security Act”, or the date the Member becomes covered by any other group plan that provides hospital, surgical, or medical coverage and under which the Member was not covered immediately before termination under the Group Agreement.

<u>Contract</u>	<u>Form Number</u>
Certificate of Coverage	HMO/CO COC-1 03/97
Certificate of Coverage	HMO/CO COC-2 05/98
Certificate of Coverage	HMO/CO COC-3 10/98

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**Recommendation No. 15:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108(2), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has removed this termination provision from all forms. The Company should work with the Division of Insurance to ensure that no member was harmed because of this limitation.

**Issue E7: Failure to provide correct information concerning eligibility for conversion coverage.**

Section 10-16-108(2), C.R.S., Conversion and continuation privileges, Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations, states:

- (d) A group contract or group service contract that provides for *continued coverage after an employee is terminated*, as required by paragraph (a) of this subsection (2), *shall also include a provision allowing a covered employee or surviving spouse or dependent, at the expiration of such continued coverage, to obtain* from the insurer underwriting the group contract or group service contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, *an individual service contract or contract providing hospital, medical-surgical, or other health services which shall conform to the same type of descriptions, limitations, and requirements as those specified for converted policies pursuant to subparagraph (I) of paragraph (c) of subsection (1) of this section.* [Emphases added.]

Section 10-16-108(4), C.R.S., Special Provisions for small group health benefit plans, states:

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

The Company's Certificates of Coverage are not in compliance with Colorado law in that they:

1. Provide that the Member must initiate conversion coverage. The law requires that upon contract termination, *the carrier* must initiate conversion coverage by offering conversion coverage to any individual who has lost coverage due to termination of that contract.
2. Provide for conversion coverage to be made available when COBRA Continuation Coverage ceases but do not state that conversion coverage must also be made available upon the expiration of any *state* continuation coverage.

3. Provide for the denial of conversion coverage to a Dependent if the group contract terminates in its entirety. The carrier must offer conversion coverage to all covered individuals in a small group upon termination of the group contract for any reason other than replacement with another group policy, or fraud and abuse in procuring and utilizing coverage. If the Member (whether Employee or Dependent) was covered under the contract at the date of termination, then conversion coverage must be offered to that individual.

The Company's Certificates state in the section "Continuation and Conversion":

D. Conversion Privilege.

*Conversion is not initiated by HMO. The conversion privilege set forth in this subsection must be initiated by the eligible Member.* [Emphasis added.] The Contract Holder is responsible for giving notice of the conversion privilege in accordance with its normal procedures; however, in the event continuation coverage ceases pursuant to expiration of COBRA benefits as described in the COBRA Continuation Coverage section of this Certificate, the Contract Holder shall notify the Member at some time during the 180-day period prior to the expiration of coverage.

1. Eligibility.

In the event a Member ceases to be eligible for coverage under this Certificate and has been continuously enrolled for 3 months under HMO, such person may, within 31 days after termination of coverage under this Certificate, convert to individual coverage with HMO, effective as of the date of such termination, without evidence of insurability provided that Member's coverage under this Certificate terminated for one of the following reasons:

- d. Continuation coverage ceased under the *COBRA Continuation Coverage* [emphasis added] section of this Certificate. . . .
2. A Covered Dependent has the right to convert when coverage is terminated for any reason (subject to the ability of minors to be bound by contract), except upon:
    - a. *Termination of the Group Agreement in its entirety* [emphasis added]; or
    - b. Termination of coverage with respect to Member's or Covered Dependent's eligible class; or
    - c. Failure of the Subscriber to make any required payments.

<u>Contract</u>	<u>Form Number</u>
Certificate of Coverage	HMO/CO COC-1 03/97
Certificate of Coverage	HMO/CO COC-2 05/98
Certificate of Coverage	HMO/CO COC-3 10/98

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**Recommendation No. 16:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-108(2), and 10-16-108(4), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all forms to provide correct information concerning eligibility for conversion coverage.

**Issue E8: Failure to provide for continuation of coverage for a Member who is an inpatient on the date of contract termination, until release from the facility.**

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, effective July 1, 1997, states:

- (4) (a) Every contract between a carrier and a participating provider shall include provisions for continuity of care as specified in this subsection (4).
- (c) In the circumstance that coverage is terminated for any reason other than nonpayment of the premium, fraud, or abuse, every managed care plan shall provide for continued care for covered persons being treated at an in-patient facility until the patient is discharged.

The Company's Certificates of Coverage are not in compliance with law in that provision is made for termination of a Member's coverage twelve (12) months from the termination date of the Group Agreement, if a Member is confined as an inpatient in a hospital or skilled nursing facility. Continued coverage may only be denied in the event of nonpayment of premium, fraud, or abuse. The Company's Certificates of Coverage cannot contain provisions contrary to those required in provider contracts. The Company's Certificates of Coverage state:

Continuation and Conversion

Extension of Benefits While Member is Receiving Inpatient Care.

Any Member who is receiving inpatient care in a Hospital or Skilled Nursing Facility on the date coverage under this Certificate terminates is covered in accordance with the Certificate only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, *until the earlier of* [emphasis added]:

1. the date of discharge from such inpatient stay; or
2. determination by the HMO Medical Director in consultation with the attending Physician, that care in the Hospital or Skilled Nursing Facility is no longer Medically Necessary; or
3. the date the contractual benefit limit has been reached; or
4. the date the Member becomes covered for similar coverage from another health benefits plan; or
5. *12 months from the termination date of the Group Agreement.* [Emphasis added.]

Contract

Form Number

Certificate of Coverage  
Certificate of Coverage  
Certificate of Coverage

HMO/CO COC-1 03/97  
HMO/CO COC-2 05/98  
HMO/CO COC-3 10/98

**Recommendation No. 17:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-705(4), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all forms to provide continuity of care as required by law. The Company should work with the Division of Insurance to ensure that no person was denied coverage or had coverage limited because of the contract wording.

**Issue E9: Failure to cover some services and supplies required to be covered under the Basic and Standard Plans.**

Section 10-16-104(13), C.R.S., Mandatory Coverage Provisions, Diabetes, effective July 1, 1998, states:

- (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 diabetes that shall include equipment, *supplies* [emphasis added], and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items pursuant to Colorado law, and, if coverage is provided through a managed care plan, such qualified provider shall be a participating provider in such managed care plan.
- (b) Diabetes outpatient self-management training and education when prescribed shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.
- (c) The benefits provided in this subsection (13) are subject to the same annual deductibles or copayments established for all other covered benefits within a given policy.

Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), and 10-16-108.5(8), C.R.S., Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado, states:

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

- C. Family Planning Services – Family planning services must be included as a covered benefit under both the standard and basic health benefit plans. At a minimum, family planning services shall include maternity care, prenatal and postnatal care and counseling, treatment and screening as appropriate for sexually transmitted diseases, *sterilization* [emphasis added], contraceptives, and contraception counseling.

Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, C.R.S., 10-16-105(7.2), C.R.S., and 10-16-108.5(8), C.R.S., states:

Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado, January 1, 1998

TABLES 1 and 2, BASIC and STANDARD HEALTH BENEFIT PLANS

19. EXCLUSIONS Standard exclusions, including cosmetic care; war; care that is not medically necessary; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws<sup>22</sup>; no-fault auto coverage or employers liability laws; marital or social counseling; educational training problems; learning disorders; transplants except for those listed above; *dental care except for accidents* [emphasis added]; TMJ (except that TMJ that has a medical basis is covered); experimental and investigational procedures; infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; hearing aids and fitting; eye glasses and contact lenses; nursing home care except as specifically otherwise covered under this plan; and custodial care.

The Company's Basic and Standard Plan *Certificate of Coverage* is not in compliance with law in that it provides for the following exclusions:

1. *Dental Services* required as the result of accidental injuries. Regulation 4-6-5 requires coverage for dental care required as the result of injuries. The Company's forms state:

Exclusions and Limitations

A. Exclusions.

- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and *treatment of injuries* [emphasis added] to or diseases of the teeth. Dental services related to the gums, including but not limited to, apicoectomy (dental root resection), orthodontics, root canal treatment, soft issue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, and dental implants are not covered.

2. *Diabetes Supplies*. As of July 1, 1998, the law requires coverage of such supplies. The Company did not file or issue an amendment to the Basic and Standard Plans in 1998, to provide coverage for such supplies. The Company did provide a copy of a Member Bulletin, effective in 1999, that stated that diabetes supplies would be covered effective "immediately." The Company's Certificate states:

Exclusions and Limitations

A. Exclusions.

- Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as *syringes*, incontinence pads, elastic stockings, and *reagent strips*.
- Specific injectable drugs, including:
  2. *needles, syringes and other injectable aids*;

[Emphases added.]

3. Sterilization. The law requires sterilization to be covered as part of the Family Planning benefit. The Company's Certificate states:

Exclusions and Limitations

B. Exclusions.

- Voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

Contract

Form Number

Certificate of Coverage

HMO/CO-SG COC-2 1/98

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**Recommendation No. 18:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104(13), C.R.S. and Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Basic and Standard Plan Certificate of Coverage to correctly reflect all services and supplies to be covered as required by law. The Company should work with the Division of Insurance to ensure that no eligible person was denied coverage for dental injuries or diabetes supplies because of the contract wording.

**Issue E10: Failure to correctly cover complications resulting from non-covered services.**

Section 10-16-102(5), C.R.S., Definitions, states:

“Basic health care services” means health care services that an enrolled population of a health maintenance organization organized pursuant to the provisions of part 4 of this article might reasonably require in order to maintain good health, including as a minimum, emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services.

The Company’s Certificates of Coverage are not in compliance with the requirements of Colorado law in that they exclude coverage for complications arising from voluntary sterilizations and reversal of voluntary sterilizations. Voluntary sterilizations (other than under the Basic and Standard Plans), and reversal of sterilizations, may be excluded. However, services that are medically necessary due to complications from these surgeries and that fall within the realm of basic health care services, must be covered. The Company’s Certificates of Coverage state:

Exclusions and Limitations

A. Exclusions.

- Reversal of voluntary sterilizations, including related follow-up care and *treatment of complications* of such procedures.
- Voluntary sterilizations, including related follow-up care and *treatment of complications* of such procedures.

[Emphases added.]

Contract

Form Number

Certificate of Coverage  
Certificate of Coverage  
Certificate of Coverage  
Certificate of Coverage

HMO/CO COC-1 03/97  
HMO/CO COC-2 05/98  
HMO/CO COC-3 10/98  
HMO/CO-SG COC-2 1/98

**Recommendation No. 19:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102(5), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Certificates of Coverage, and all forms that contain the same or similar exclusions, to provide treatment of complications resulting from non-covered services. The Company should work with the Division to ensure that no Member was denied coverage for surgical complications due to these restrictions.

**Issue E11: Failure to provide for coverage of biologically based mental illness on the same basis as physical illness, and to amend some plans to provide the mandated coverage for biologically based mental illness.**

Section 10-16-104(5.5), C.R.S., Biologically based mental illness, states:

- (a) (I) Every group policy, plan certificate, and contract of a carrier subject to the provisions of part 2, 3, or 4 of this article, except those described in section 10-16-102 (21) (b), shall provide coverage for the treatment of biologically based mental illness that is no less extensive than the coverage provided for any other physical illness.
- (II) As used in this subsection (5.5), "biologically based mental illness" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
- (b) Benefits provided under this subsection (5.5) are not required to be provided to the extent that such benefits duplicate benefits required to be provided under subsection (5) of this section.

The Company's forms are not in compliance with law in that:

1. An amendment to the Certificate of Coverage dated March 1997 to bring it into compliance with the law effective January 1, 1998, does not appear to have been filed or issued during the examination period, and Members do not appear to have been notified of the availability of benefits for biologically based mental illnesses until some time in 1999.
2. The Certificates of Coverage dated May 1998 and October 1998 and the Member Bulletin issued in 1999, state that benefits will be payable for the *medical* treatment of biologically based mental illness. The intent of the law is to cover treatment of biologically based mental illness at the same level as physical illness. Treatment of biologically based mental illness is frequently therapy and therapy for these illnesses must be covered.

The Company's Certificates of Coverage and the Bulletin state:

J. Mental Health Benefits

A Member is covered for services for the treatment of the following Mental or Behavioral Conditions through Participating Behavioral Health Providers.

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

2. Inpatient benefits and Partial Hospitalization visits are covered for medical, nursing, counseling or therapeutic services in an inpatient, non-hospital residential facility, appropriately licensed by the appropriate regulatory authority. Coverage is subject to the maximum number of days, if any shown on the Schedule of Benefits.
  
4. Benefits shall be covered for the medical treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. The following mental illnesses shall be covered:
  - a. Schizophrenia;
  - b. Schizoaffective disorder;
  - c. Major depressive disorder;
  - d. Bipolar disorder;
  - e. Specific obsessive-compulsive disorder; and
  - f. Panic disorder.

*All outpatient and inpatient benefits detailed above must first be exhausted before the Member is eligible for this benefit. [Emphasis added.]*

3. The Certificates of Coverage dated May 1998 and October 1998 and the Member Bulletin issued in 1999, state that all outpatient and inpatient benefits for *other than* biologically based mental illnesses must be exhausted before the mandated benefits for biologically based mental illnesses will be provided. Benefits for therapy for these illnesses cannot reduce the therapy benefits available for other than biologically based mental illnesses. It is contrary to legislative intent to apply the benefits for biologically based mental illness therapy against the day and visit limits applicable to therapy for other mental illnesses.

The Company's Certificates of Coverage and the Bulletin state:

4. Benefits shall be covered for the *medical* [emphasis added] treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. The following mental illnesses shall be covered:
  - a. Schizophrenia;
  - b. Schizoaffective disorder;
  - c. Major depressive disorder;
  - d. Bipolar disorder;
  - e. Specific obsessive-compulsive disorder; and
  - f. Panic disorder.

*All outpatient and inpatient benefits detailed above must first be exhausted before the Member is eligible for this benefit. [Emphasis added.]*

<u>Contract</u>	<u>Form Number</u>
Certificate of Coverage	HMO/CO COC-1 03/97
Certificate of Coverage	HMO/CO COC-2 05/98
Certificate of Coverage	HMO/CO COC-3 10/98

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**Recommendation No. 20:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104(5.5), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised these and all forms that contain similar language to provide mental illness coverage as specified by law. The Company should work with the Division of Insurance to ensure that no eligible person was denied coverage or had coverage for mental illness limited because of the contract wording.

**Issue E12: Failure to provide for timely notification to Members upon termination of their providers' contract with the HMO.**

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, effective July 1, 1997, states:

- (7) A carrier and participating provider shall provide at least sixty days written notice to each other before terminating the contract without cause. The carrier shall make a good faith effort to provide written notice of termination *within fifteen working days* [emphasis added] after receipt of or issuance of a notice of termination to all covered persons that are patients seen on a regular basis by the provider whose contract is terminating, regardless of whether the termination was for cause or without cause. Where a contract termination involves a primary care provider, all covered persons that are patients of that primary care provider shall also be notified. Within five working days after the date that the provider either gives or receives notice of termination, the provider shall supply the carrier with a list of those patients of the provider that are covered by a plan of the carrier.

The Company's Certificates of Coverage are not in compliance with law in that they provide for notification to affected Members of their PCP's termination from the network within a variable period of thirty(30) days following the termination of the PCP's contract.

The Company's Certificates of Coverage state:

General Provisions

F. Independent Contractor Relationship

4. HMO cannot guarantee the continued participation of any Provider or facility with HMO. In the event a PCP terminates its contract or is terminated by HMO, HMO shall provide notification to Members in the following manner:
  - a. within [*thirty*] [emphasis added] days of the termination of a PCP contract to each affected Subscriber, if the Subscriber or any Dependent of the Subscriber is currently enrolled in the PCP's office; and . . . .

The Company presented ten (10) Certificates of Coverage actually issued to small groups during the examination period for review. All ten (10) had the above wording in the Independent Contractor Relationship Section.

<u>Contract</u>	<u>Form Number</u>
Certificate of Coverage	HMO/CO COC-1 03/97
Certificate of Coverage	HMO/CO COC-2 05/98
Certificate of Coverage	HMO/CO COC-3 10/98
Certificate of Coverage	HMO/CO-SG COC-2 1/98

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**Recommendation No. 21:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-705(7), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all forms to accurately reflect the time frame required by law for notification to Members upon the termination of their providers' contract with the HMO.

**Issue E13: Failure to Include the Mandatory Disclosure Statement on Small Group  
Application Forms.**

Regulation 4-6-5(III)(E), Implementation of Basic and Standard Health Benefit Plans, Rules, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), and 10-16-108.5(8), C.R.S., states:

The following disclosure statement, prominently displayed in bold type capital letters no smaller than 14 point, shall appear on all small employer marketing materials (except the Colorado Comprehensive Health Benefit Plan Description Form pursuant to Division Regulation 4-2-20), small employer application forms, and small employer renewal notices, and on all written refusals to insure which are related to health coverage for a business group of one.

“COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN.”

The AETNA US HEALTHCARE EMPLOYER APPLICATION FORM in use during the examination period did not contain the required disclosure statement.

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**Recommendation No. 22:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-5(III)(E). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Small Group Application forms to include the mandatory disclosure statement.

**Issue E14: Failure to state correctly in Membership Certificates that the Open Enrollment Period is a period of at least one month.**

Section 10-16-408, C.R.S., Open Enrollment, states:

- (1) After a health maintenance organization has been in operation twenty-four months, it shall have an annual open enrollment period of *at least one month* [emphasis added] during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. A health maintenance organization may apply to the commissioner for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The commissioner shall approve or deny such application within thirty days of the receipt thereof from the health maintenance organization.
- (2) Health maintenance organizations providing or arranging for services exclusively on a group contract basis may limit the open enrollment provided for in subsection (1) of this section to all members of the group or groups covered by such contracts.

The Company's Certificates of Coverage are not in compliance with Colorado law in that they provide for an open enrollment period of *ten or more consecutive working days*. The law requires that the open enrollment period shall be a period of *at least one month*.

The Company's Certificates of Coverage state:

Definitions

Open Enrollment Period. A period of not less than *ten (10) consecutive working days* [emphasis added], each calendar year, when eligible enrollees of the Contract Holder may enroll in HMO without a waiting period or exclusion or limitation based on health status or, if already enrolled in HMO, may transfer to an alternative health plan offered by the Contract Holder.

Contract

Form Number

Certificate of Coverage  
Certificate of Coverage  
Certificate of Coverage

HMO/CO COC-1 03/97  
HMO/CO COC-2 05/98  
HMO/CO COC-3 10/98

**Recommendation No. 23:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-408, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all forms to specify that the enrollment period shall be at least thirty (30) days.

**Issue E15: Failure to provide full and correct information concerning Special Enrollees.**

Section 10-16-102(26), C.R.S., Health Care Coverage, Definitions, effective July 1, 1997, states:

“Late enrollee” means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:

- (d) A person becomes a dependent of a covered person through marriage, birth, adoption, or placement for adoption and requests enrollment no later than thirty days after becoming such a dependent. In such case, coverage shall commence *on the date the person becomes a dependent* [emphasis added] if a request for enrollment is received in a timely fashion before such date.

Regulation 4-2-18, Concerning the method of crediting and certifying creditable coverage for pre-existing conditions, promulgated under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., as amended by Senate Bill 97-054, states:

A. Application of federal laws concerning creditable coverage

- 2. The federal regulations found in 45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; 45 C.F.R. 146.117; 45 C.F.R. 146.119(b); and 45 C.F.R. 146.125 (a)(3), (b), (d) and (e) adopted by the Department of Health and Human Services are hereby incorporated by reference, and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S. These federal regulations concern methods of counting creditable coverage, requirements concerning a health plan’s duty to provide certificates of creditable coverage to insureds, *special enrollment periods* [emphasis added], the effective dates for certification requirements, transition rules for counting creditable coverage, and transition rules for certificates of creditable coverage. This rule does not include later amendments to, or editions of, the above-referenced regulations.

Health Insurance Portability and Accountability Act of 1996, through the Public Health Service Act, Sec. 2701(f), and the Employee Retirement Income Security Act of 1974, Section 101, Special Enrollment Periods, states:

- (2) For dependent beneficiaries. -- (A) In general. -- If --(i) a group health plan makes coverage available with respect to a dependent of an individual, (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan *but for a failure to enroll during a previous enrollment period*), and (iii) a person becomes such a dependent of the individual

*through marriage, birth, or adoption or placement for adoption* [emphasis added], the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

Department of Labor, Pension and Welfare Benefits Administration, April 1997 Publication entitled “Questions & Answers: Recent Changes in Health Care Law” clarified the intent of the federal legislation (with which Colorado complies), by publishing the following:

Model Description

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. *In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents* [emphasis added], provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

The Company’s Certificates of Coverage do not provide for the enrollment of the following Special Enrollees, and amendments to bring these forms into compliance with law were not filed or issued during the examination period.

The Company’s Certificates of Coverage are not in compliance with law in the following areas. The forms:

1. Do not provide for a Special Enrollment Period for the employee’s *existing* dependents when the employee experiences a *change in family status* such as marriage, birth, adoption or placement for adoption but rather provide only for the enrollment of *newly eligible dependents* of an already enrolled employee or *employees and dependents who have lost other coverage*.
2. Do not provide for coverage to commence *on the date the Special Enrollee becomes a dependent*.

The law requires that in the event of a change in family status, the employee and all of his or her dependents who were not previously enrolled, whether or not they had previously declined coverage, may enroll in the plan and be covered from the date they become dependents, and will not be considered late enrollees. The Company’s Certificate(s) of Coverage:

- Dated March 1997, and for which an amendment does not appear to have been filed or issued, states:

Eligibility and Enrollment

Notification of Change in Status.

It shall be a Member's responsibility to notify HMO of any changes which affect the Member's coverage under this Certificate. Such status changes include, but are not limited to, change of address, change of Covered Dependent status, and enrollment in Medicare or any other group health plan of any Member.

Additionally, if requested, a Subscriber must provide to HMO, within 31 days of the date of the request, evidence satisfactory to HMO that a dependent meets the eligibility requirements described in this Certificate.

An eligible individual and any eligible dependents may be enrolled if the eligible individual's spouse was covered under another health benefit plan and *lost coverage* [emphasis added] because of termination of coverage, for reasons other than gross misconduct, within 31 days of the loss of coverage even though it is not during the Open Enrollment Period. The eligible individual or the eligible dependent will not be subject to the late enrollment provision described below. HMO's completed change form must be submitted to the Contract Holder within 31 days of the event causing the change in status.

- Dated May 1998 and October 1998, state:

Eligibility and Enrollment

5. Notification of Change in Status.

An eligible individual and any eligible dependents may be enrolled during a special enrollment period. A special enrollment period occurs when:

- a. an eligible individual or an eligible dependent is covered under another group health plan or other health insurance coverage when initially eligible for coverage under HMO;
- b. the eligible individual or eligible dependent declines coverage [in writing] under HMO;
- c. the eligible individual or eligible dependent *loses coverage* [emphasis added] under the other group health plan or other health insurance coverage for one of the following reasons:
  - i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or

- ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employed contributions towards the other coverage have been terminated

Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing.

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of the HMO Certificate of Coverage; and

- d. the eligible individual or eligible dependent enrolls within [30-31] days of the loss.

The effective date of coverage will be the *first day of the first calendar month following the date the completed request for enrollment is received.* [Emphasis added.]

The eligible individual or the eligible dependent enrolled during a special enrollment period will not be subject to any late enrollment or preexisting condition provision described in this Certificate.

Contract

Form Number

Certificate of Coverage  
Certificate of Coverage  
Certificate of Coverage

HMO/CO COC-1 03/97  
HMO/CO COC-2 05/98  
HMO/CO COC-3 10/98

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**Recommendation No. 24:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102(26), C.R.S. and Regulation 4-2-18(A)(2). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to ensure coverage is provided for all special enrollees as specified by law. It should work with the Division to ensure that no eligible person was improperly denied enrollment.

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**Issue E16: Failure to comply with the required procedures for utilization review.**

Section 10-16-113, C.R.S., Procedure for denial of benefits, effective July 1, 1997, states:

- (7) *Nothing in this section shall preclude or deny the right of the covered individual to seek any other remedy or relief, and nothing in this section shall be a condition precedent to any legal proceeding.* [Emphasis added.]

Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1107, 10-3-1110, and 10-16-109, C.R.S., states:

III. Applicability and scope

*. . . Nothing in this regulation shall be construed to supplant any appeal or due process rights that a person may have under federal or state law.*  
[Emphasis added.]

VI. Procedures for review decisions

- B. For prospective review determinations, a health carrier shall make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, “necessary information” includes the results of any face-to-face clinical evaluation or second opinion that may be required.

- 1) In the case of a determination to certify an admission, procedure or service, *the carrier shall notify the provider rendering the service by telephone within one (1) working day of making the initial certification; and shall provide written or electronic confirmation of the telephone notification to the covered person and/or the provider within two (2) working days of making the initial certification.*
- 2) In the case of an adverse determination, *the carrier shall notify the provider rendering the service by telephone within one (1) working day of making the adverse determination; and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within one (1) working day of making the adverse determination.*

- C. For concurrent review determinations, a health carrier shall make the determination within one (1) working day of obtaining all necessary information.

- 1) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone the provider

rendering the service within one (1) working day of making the certification; and shall provide written or electronic confirmation to the covered person and/or the provider within one (1) working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

- 2) In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination; and shall provide written or electronic notification to the covered person and the provider within one (1) working day of the telephone notification. The service shall be continued without liability to the covered person until the covered person and the provider rendering the service have been notified of the determination.

D. For retrospective review determinations, a health carrier shall make the determination within thirty (30) working days of receiving all necessary information.

- 1) In the case of a certification, the carrier may notify in writing the covered person and the provider rendering the service.
- 2) In the case of an adverse determination, *the carrier shall notify in writing the provider rendering the service and the covered person within five (5) working days of making the adverse determination.*

## VIII. Appeals of Adverse Determinations

### I. Standard Appeals

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal.
  - (6) Notice of the covered person's right to contact *the commissioner's office. The notice shall contain the telephone number and address of the commissioner's office.* [Emphasis added.]

The Company's written utilization review procedures as described in the Certificates of Coverage are not in compliance with law. The Company's procedures appear to combine those required for complaints with those required for utilization review decisions.

The Certificate of Coverage:

- Dated March 1997, and for which an amendment does not appear to have been filed or issued:
  1. Provides for all decisions concerning grievances to be made within 30 days of receipt. The time frame for such decisions is determined by the nature of the grievance. When it relates to a *retroactive* utilization review, a time frame of thirty (30) days is permissible. However, for grievances related to prospective and concurrent utilization, the decision must be provided in writing within twenty (20) working days.
  2. Provides for written notice stating the result of the review to be forwarded to the *Member* within *ten (10) working days* of the date of the decision. In the case of a grievance requiring a utilization review determination, notification of the decision must be forwarded within:
    - A. For Prospective review:
      - (a) Certification:
        - (i) One (1) working day by telephone to the provider; and
        - (ii) Two (2) working days in writing or electronically to the Member and/or the provider; after certification.
      - (b) Denial:
        - (i). One (1) working day to the provider by telephone; and
        - (ii). One (1) working day to the Member and the provider in writing or electronically; after denial.
    - B. For Concurrent review:
      - a) Certification of an extended stay or additional services:
        - (i). One (1) working day to the provider by telephone after certification; and
        - (ii). One (1) working day to the Member and/or the provider in writing or electronically after telephone notification.
      - (b) Denial:
        - (i) One (1) working day of the denial to the provider by telephone; and
        - (ii) One (1) working day in writing or electronically to the Member and the provider after telephone notification.
    - C. For Retrospective review denial, within five (5) working days in writing to the provider and the Member after the decision to deny.

- Dated May 1998 and October 1998, in the case of a concurrent review (incorporated with prospective review as “grievance review”) provide for *review and decision* within two (2) days of obtaining all necessary information, rather than one (1) working day as provided by law.
- Dated March 1997, May 1998, and October 1998 deny a Member the right to:
  1. Investigation of a complaint by the Division of Insurance;
  2. File a complaint with the Division of Insurance; and
  3. Establish any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the Group Agreement or Certificate by HMO, or any matter within the scope of the grievance resolution process of any complaint, grievance or grievance appeal.

The Company cannot deny:

- A Covered Person any of the above rights; or
- The Division of Insurance the right to investigate a complaint;

Prior to exhaustion of the grievance procedure;

The Company’s Certificate(s) of Coverage:

- Dated March 1997, states:

Grievance Procedure

The following procedures govern complaints, grievances, and grievance appeals made or submitted by Members.

B. Grievance Review

2. The Grievance Committee deciding the grievance shall be comprised of one or more employees of HMO. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance. The Grievance Coordinator shall review and decide the grievance within *30 days* [emphasis added] of receipt unless additional information necessary to resolve the grievance is not received during such time, or by the mutual written agreement of HMO and the Member.
3. A written notice stating the result of the review by the Grievance Committee shall be forwarded by HMO to the Member within *ten (10) working days* [emphasis added] of the date of the decision. Such notice shall include:

- a. a description of the Committee’s understanding of the Member’s grievance as presented to the Grievance Committee (i.e., dollar amount of the disputed issue, *medical facts* [emphasis added] in dispute, etc.); and . . . .

E. Exhaustion of Process.

The foregoing procedures and process are mandatory and must be exhausted prior to:

1. any investigation of a complaint by the Division of Insurance; or
2. the filing of a complaint with the Division of Insurance; or
3. the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the Group Agreement or Certificate by HMO, or any matter within the scope of the grievance resolution process of any complaint, grievance or grievance appeal.

- Dated May 1998 and October 1998, state:

Grievance Procedure

The following procedures govern complaints, grievances, and grievance appeals made or submitted by Members.

B. Grievance Review

2. The Grievance Coordinator deciding the grievance shall be comprised of one or more employees of HMO. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance. The Grievance Coordinator shall review and decide the grievance within *2 days* [emphasis added] of obtaining all necessary information to resolve the grievance or by the mutual written agreement of HMO and the Member. For retrospective review determinations, HMO shall make a determination within 30 days of receiving all necessary information.

E. Exhaustion of Process.

The foregoing procedures and process are mandatory and must be exhausted prior to:

1. any investigation of a complaint by the Department of Insurance; or

2. the filing of a complaint with the Department of Insurance; or
3. the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the Group Agreement or Certificate by HMO, or any matter within the scope of the grievance resolution process of any complaint, grievance or grievance appeal.

Contract

Form Number

Certificate of Coverage  
Certificate of Coverage  
Certificate of Coverage

HMO/CO COC-1 03/97  
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HMO/CO COC-3 10/98

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**Recommendation No. 25:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113(7), C.R.S., and Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its utilization review procedures as described in the Certificates of Coverage to comply with Colorado law.

**Issue E17: Failure to file forms in accordance with law and to maintain records of filings.**

Section 10-16-107.2(2), C.R.S., Filing of health policies, states:

All sickness and accident insurers, health maintenance organizations, nonprofit hospital and health service corporations, and other entities providing health care coverage authorized by the commissioner to conduct business in Colorado shall also submit to the commissioner a list of any *new policy form, application, endorsement, or rider at least thirty-one days before using such policy form, application, endorsement, or rider* [emphasis added] for any health coverage. Such listing shall also contain a certification by an officer of the organization that each new policy form, application, endorsement, or rider proposed to be used complies, to the best of the insurer’s good faith knowledge and belief, with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

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

Group sickness and accident insurance – conversion privileges.

(d)(XV)(A) An employee or member who is entitled to make *application* [emphasis added] for a converted policy pursuant to the provisions of paragraph (c) of this subsection (1) shall be given written notice of the existence of the conversion privilege at least fifteen days prior to the expiration of the thirty-one-day conversion period established by the group policy. If the employee or member is not given notice of his conversion rights, the employee or member shall have an additional period within which to exercise such conversion privilege. . . .

(B) . . . If an employee or member is permitted an additional period for conversion, as provided in this subparagraph (XV), and if *written application* [emphasis added] for the converted policy, accompanied by the initial premium is made within the additional period, . . .

The Company was not in compliance with law in that it did not file all forms prior to use. This includes, among others, the Company’s “Individual Conversion Request” form. These forms are application forms and as such must be filed. The Company’s Certificates of Coverage state in the section “Continuation and Conversion”:

D. Conversion Privilege.

1. Eligibility.

In the event a Member ceases to be eligible for coverage under this Certificate and has been continuously enrolled for 3 months under HMO, such person may, within 31 days after termination of coverage under this Certificate convert to individual coverage with HMO . . . provided that . . .

Any Member who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as HMO may have in effect at the time of Member's *application for conversion*, [emphasis added] . . .

<u>CONTRACT TYPE</u>	<u>FORM NO.</u>
Certificate of Coverage for Basic and Standard Plans	HMO/CO-SG COC-2 01/98
Individual Conversion Requests	No form numbers

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**Recommendation No. 26:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-107.2(2) and 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure timely filing of forms, including application forms.

**Issue E18: Failure to uniformly provide for first level appeal decision notification within twenty (20) working days.**

Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1107, 10-3-1110, and 10-16-109, C.R.S., states:

VIII. Appeals of Adverse Determinations

I. Standard Appeals

A. First Level Appeal Review

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within *twenty (20) working days following the request for an appeal*. [Emphasis added.]

The Company's written utilization review procedures as described in the Certificates of Coverage are not in compliance with law. The Company's forms provide for the Company to extend the time frame for first level appeal decision notification if additional information is required and is not received within the twenty day decision notification time frame, or if the Company obtains the written agreement of the Member for a delay. The law provides for first level appeal decision notification to be made within twenty (20) working days of the request for appeal. It does not provide for any delay of decision notification at this level. The Certificates of Coverage dated May 1998 and October 1998, state:

Grievance Procedure

The following procedures govern complaints, grievances, and grievance appeals made or submitted by Members.

D. Adverse Determinations (First Level Appeals)

2. The reviewers handling the adverse determination shall be comprised of one or more employees of HMO. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance. The reviewers shall review the grievance and notify in writing both the Member and the attending or ordering Provider of the decision within 20 days of receipt *unless additional information necessary to resolve the grievance is not received during such time, or by the mutual written agreement of HMO and the Member*. [Emphasis added.]

Contract  
Certificate of Coverage  
Certificate of Coverage

Form Number  
HMO/CO COC-2 05/98  
HMO/CO COC-3 10/98

**Recommendation No. 27:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-2-17(VIII)(I)(A) In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has removed from all forms the extended time frame wording for first level review appeals.

**Issue E19: Failure to conform Group Agreements and Service Agreements to the requirements of law concerning contract terminations.**

Section 10-16-201.5(1), C.R.S., Renewability of health benefit plans, states:

A carrier providing coverage under a health benefit plan *shall not 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) The carrier elects to discontinue offering and nonrenew all of its individual, small group, . . .
  - (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; or
  - (j) With respect to coverage of an employer that is made available only through one or more bona fide associations, the membership of an employer ceases.
- The Company's Group Agreements are not in compliance with law in that:
    1. The Group Agreements dated March 1997 and May 1998, provide for termination of the Group Agreement by the Company at will, upon 30-180 days notice. With some exceptions, the law provides for guaranteed renewability of the contract at the option of the contractholder. The Group Agreements state:

Contract Holder Termination

      - A. This Group Agreement may be terminated by HMO or the Contract Holder on any Premium due date by giving [30-180] days' prior written notice.

2. The Group Agreement dated March 1997 provides for termination of the Group Agreement by the Company for reasons other than those permitted by law. The Company cannot terminate the contract for reasons it believes will *lead to* non-payment. While premiums continue to be paid, the contract may not be terminated (except for other reasons specified by law).

This Group Agreement does not appear to have been:

- Amended; or
- Refiled until January 1998 for small groups and May 1998 for other groups;

In order to bring it into compliance with the law effective July 1, 1997. The Group Agreement states:

Contract Holder Termination

F. HMO may terminate this Group Agreement if the Contract Holder:

2. makes an assignment for the benefit of creditors or similar undertaking;
3. admits in writing its inability to pay debts as they come due;
4. consents to the appointment of a trustee or receiver; or if a trustee or receiver is appointed for the Contract Holder or for all or a substantial part of its properties or business;
5. becomes insolvent;
6. files a petition in bankruptcy;
7. files a petition seeking any reorganization, arrangement, composition or similar relief under any federal or state law regarding insolvency or relief for debtors; or
8. has begun any voluntary or involuntary liquidation process.

Termination will be effective immediately following the date HMO gives the Contract Holder written notice of termination.

- The Company’s Service Agreements are not in compliance with law in that they provide for termination “at any time” subject to reasons permissible by law, but also provide for termination of the Agreement by the HMO at will, upon notice 30 days prior to the Group Agreement anniversary date.

The Service Agreement dated March 1997 (and which does not appear to have been amended or refiled until June 1998), and the Service Agreement dated June 1998, state:

C. Term and Termination

3. Except as otherwise provided in this Section, either HMO or the Contract Holder may terminate this Agreement by giving written notice to the other party at least 30 days prior to the Group Agreement anniversary date. Such terminations shall be effective on the Group Agreement anniversary date.

<u>Contract</u>	<u>Form Number</u>
Group Agreement	HMO/CO GA-1 03/97
Group Agreement	HMO/CO-SG GA-2 01/98
Group Agreement	HMO/CO GA-2 05/98
Service Agreement	HMO/CO SERVAGREE-1 (03/97)
Service Agreement	HMO/CO SERVAGREE-2 (06/98)

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**Recommendation No. 28:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5(1), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its group agreements to conform to law.

**Issue E20: Failure to conform Service Agreements to the requirements of law concerning dependent eligibility.**

Section 10-16-102(43), C.R.S., Health Care Coverage, Definitions, states:

“Small group sickness and accident insurance,” “small group plan,” and “small group policy” mean that form of group sickness and accident insurance issued by an entity subject to part 2 of this article, that form of group service or indemnity type contract issued by an entity organized pursuant to the provisions of part 3 of this article, or that form of policy issued by an entity organized pursuant to the provisions of part 4 of this article which provides coverage to small employers located in Colorado. These terms include a bona fide association plan if such plan provides coverage to one or more eligible employees of a small employer in Colorado.

Section 10-16-104(6)(b), C.R.S., Dependent children, states:

No entity described in paragraph (a) of this subsection (6) shall refuse to provide coverage for a dependent child under the health plan of the child’s parent for the sole reason that the child:

- (II) Does not live in the insurer’s service area, notwithstanding any other provision of law restricting enrollment to persons who reside in an insurer’s service area; or . . . .

Exhibit A – Eligibility Criteria, of the Service Agreements contains a requirement that Dependents, except for student dependents, live within the Service Area for at least nine (9) months of the year to be eligible for coverage. Colorado law does not permit the exclusion from coverage of dependents who live outside the service area, regardless of the term of that residence. The same contract terms that apply to a dependent who is a resident of the service area apply to a dependent who is not a resident of the service area.

The Company’s Service Agreements state:

- B. . . . An employee’s dependents are eligible for HMO membership if they qualify under the rules set forth in the applicable Group Agreement and Certificate. Dependents, except for student dependents, must live within the HMO Service Area at least nine (9) months of the year to be eligible for coverage.

Contract

Form Number

Service Agreement  
Service Agreement

HMO/CO SERVAGREE-1 (03/97)  
HMO/CO SERVAGREE-2 (06/98)

**Recommendation No. 29:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104(6)(b), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Service Agreements to conform to the requirements of law concerning dependent eligibility.

**Issue E21: Failure to provide for conversion coverage of all medically certified disabled dependents by restricting the conversion privilege to a developmentally disabled or physically handicapped dependent.**

Section 10-16-102(14), C.R.S., Definitions, states:

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

Section 10-16-108(2), C.R.S., Conversion and continuation privileges, states:

Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.

- (d) A group contract or group service contract that provides for continued coverage after an employee is terminated, as required by paragraph (a) of this subsection (2), shall also include a provision allowing a covered employee or surviving spouse *or dependent* [emphasis added], at the expiration of such continued coverage, to obtain from the insurer underwriting the group contract or group service contract, at the employee’s, spouse’s, or dependent’s option and expense, without further evidence of insurability and without interruption of coverage, an individual service contract or contract providing hospital, medical-surgical, or other health services which shall conform to the same type of descriptions, limitations, and requirements as those specified for converted policies pursuant to subparagraph (I) of paragraph (c) of subsection (1) of this section.

The Company’s eligibility requirements for conversion coverage of a disabled child are more restrictive than permitted by law in that the Basic and Standard Plan Certificates of Coverage provide for conversion coverage to be available to a *developmentally disabled* or physically handicapped child. A child who is *medically certified as disabled* must be permitted to convert his or her coverage. Such disabilities include disabilities for mental conditions that are not developmental in nature, e.g. that are not related to mental retardation, such as schizophrenia or mental conditions related to head injury.

The Company’s Basic and Standard Plan Certificate of Coverage states:

Continuation and Conversion

[D.] Conversion Privilege.

. . . In the event a Member ceases to be eligible for coverage under this Certificate and has been continuously enrolled for 3 months under HMO, such person may, within 31 days after termination of coverage under this Certificate, convert to individual coverage in HMO, effective as of the date of such termination, without evidence of insurability provided that Member's coverage under this Certificate terminated for one of the following reasons:

- c. A Covered Dependent ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this Certificate because of the Member's age or the death or divorce of Subscriber; or . . .

HMO will offer a choice of the Colorado Basic or Standard Health Plan. The persons to be covered under the other medical expense coverage will be the Subscriber and Covered Dependents who are covered under this Certificate on the date insurance ceases, except that any *Developmentally Disabled* or physically handicapped child *beyond the maximum age for dependent children* will be covered as provided in the last paragraph. [Emphases added.]

A child beyond the maximum age for Dependent children, who is incapable of self-support because of a *Developmental Disability* [emphasis added] or physical handicap may also buy conversion coverage in the same manner as described above, if the child's coverage under this Certificate ceases because Subscriber's coverage terminates as described above.

Contract

Form Number

Certificate of Coverage

HMO/CO-SG COC-2 01/98

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**Recommendation No. 30:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108(2), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Basic and Standard Certificates of Coverage to provide for conversion coverage of a disabled dependent as required by law. The Company should work with the Division of Insurance to ensure that no disabled dependent was denied conversion coverage because of this contract wording.

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**Issue E22: Failure to provide Coordination of Benefits as required by law.**

Section 10-16-104, C.R.S., Medical assistance recipients – denial of coverage – liability to state.

- (6.7)(a) No entity subject to the provisions of this article, article 8 of this title, or section 607(1) of the federal “Employment Retirement Income Security Act of 1974,” as amended, shall refuse to enroll a person for the sole reason that the person is a medical assistance recipient for whom coverage is sought pursuant to section 26-4-518.5, C.R.S., or refuse to accept and honor an otherwise valid claim for a covered benefit which is filed in the case of an assignment under the provisions of article 4 of title 26, C.R.S.
- (b) An entity subject to this subsection (6.7) that is liable as a third party for the medical costs of a medical assistance recipient or that recovers or may recover medical costs from a third party who is liable to a medical assistance recipient for medical costs is liable to the state pursuant to section 26-4-403(3), C.R.S.

Section 10-16-408, C.R.S., Open Enrollment, states:

- (3) Except as provided in subsection (2) of this section, the enrollment policies of health maintenance organizations may not be such as to prevent or hinder the enrollment by, *or in any other manner discriminate against, persons eligible for medical benefits under titles XVIII and XIX of the federal social security act* as authorized under Public Law 89-97; such policies shall be grounds for suspension or revocation of the organization’s certificate of authority issued pursuant to this article.

Regulation 4-6-2(III), Guidelines for Coordination of Benefits, Rules, promulgated under the authority of Section 10-1-109, C.R.S., states:

A. Definitions

1. A “Coordination of Benefits (COB) provision” means a provision that is intended to avoid claims payment delays and duplication of benefits when a person *is covered by* [emphasis added] two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this regulation, it does not have to pay its benefits first.

C. Consistency with this Regulation.

If a group contract includes a COB provision, *it must be consistent with this regulation. A plan that does not include such a provision may not take the benefits of another plan as defined in Section (III)(A), "Definitions", into account when it determines its benefits.* [Emphasis added.] There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

D. NAIC Model COB Contract Provisions.

4. Prohibited Coordination and Benefit Design.

A group contract may not reduce benefits on the basis that another plan exists; except with respect to part B of Medicare; that a person is or could have been covered under another plan; or a person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

The Company's Certificates of Coverage are not in compliance with Colorado law in that they include in the Coordination of Benefits provision, the following items that are inconsistent with the Regulation:

1. A provision that coverage under the plan will *terminate* for any Member who is eligible for Medicare. Medicare *eligibility* is irrelevant to coverage of an active Employee or his or her Dependents under the group health plan. Medicare *entitlement* (coverage) for such persons:
  - May be considered when coordinating benefits, but cannot be used to deny benefits. The plan will be either primary or secondary to Medicare coverage depending upon group size, unless the Member *has rejected* coverage under the group health plan, in writing. However, for a Member of a group of fewer than 20 employees, and who has enrolled in Part A. of Medicare, the Company may coordinate benefits with both Parts A. and B. of Medicare, even if the Member has not enrolled in Part B.
  - May be a termination event only for a Member *covered* under an *individual* conversion contract. The examined contracts are *group* contracts.
2. A reference to termination of coverage due to the *eligibility* of the Employee for Medicare or *any other federal or state government programs*.

A Member's coverage cannot be:

- Terminated upon eligibility for Medicare;
- Terminated upon eligibility for Medicaid;
- Terminated upon eligibility for Workers' Compensation coverage. Coverage cannot be terminated for an active employee due to that Member's eligibility for benefits under Workers' Compensation.

The examiners acknowledge that the lead-in paragraph to the subsection "Medicare And Other Federal Or State Government Programs" states that:

The provisions of this section will apply to the maximum extent permitted by federal or state law. HMO will not reduce the benefits due any Member due to that Member's eligibility for Medicare where federal law requires that HMO determines its benefits for that Member without regard to the benefits available under Medicare.

However, such a statement does not permit the Company to include in its forms, statements that are contrary to law. If the Company's plan contains provisions that are contrary to those permitted by law, the Company's plan becomes primary to all other qualifying plans, and may be considered a non-conforming group health plan by the Internal Revenue Service.

The Company presented ten (10) Certificates of Coverage actually issued to small groups during the examination period for review. All ten (10) had the following in the section "Coordination of Benefits,"::

Benefits under this Certificate *will cease* [emphasis added] for any Member while *eligible for* [emphasis added] Medicare.

Members are considered to be eligible for *Medicare or other government programs* [emphasis added] if they:

1. Are covered under a program;
  2. *Have refused to be covered under a program for which they are eligible;*
  3. *Have terminated coverage under a program; or*
  4. *Have failed to make proper request for coverage under a program.*
- [Emphasis added.]

If coverage would cease because a Subscriber *is, or could be, eligible for Medicare or any other Federal or State government programs (such as Worker's Compensation)* any benefits in force for the Subscriber's Covered Dependents may be continued. Coverage will then continue until it terminates for some other reason under the rules of this Certificate. [Emphasis added.]

The examiners noted that none provided for eligibility of retired employees, nor did the Certificates state that the statements applied to retired employees.

<u>Contract</u>	<u>Form Number</u>
Certificate of Coverage	HMO/CO COC-1 03/97
Certificate of Coverage	HMO/CO COC-2 05/98
Certificate of Coverage	HMO/CO COC-4 10/98
Schedule of Benefits	HMO/CO SB-1 03/97
Schedule of Benefits	HMO/CO SB-2 05/98

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**Recommendation No. 31:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-104(6.7), 10-16-408, C.R.S., and Regulation 4-6-2(III). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to provide for Coordination of Benefits as required by law.

**Issue E23: Failure to maintain records.**

Regulation 1-1-7(III)(B), Market Conduct Record Retention, Records Required for Market Conduct Purposes, promulgated under the authority of Section 10-1-109, C.R.S., states:

- (1) Every insurer/carrier or related entity licensed to do business in this state shall maintain its books, records, documents and other business records so that the insurer's/carrier's or related entity's claims, rating, underwriting, marketing, complaint, and producer licensing records are readily available to the commissioner. Unless otherwise stated within this regulation, records shall be maintained for the current year plus two calendar years.

The Company has not maintained its records in accordance with law. The examiners requested that the Company provide the Certificates of Coverage issued in 1998 to ten (10) small employer groups. The Company stated verbally that it was unable to supply the Certificates of Coverage issued during 1998 to two (2) of the ten (10) groups.

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**Recommendation No. 32:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 1-1-7(III)(B). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that records are maintained in accordance with law.

**Issue E24: Failure to provide for the mandated dental anesthesia benefits for dependent children.**

Section 10-16-104(12), C.R.S., Mandatory Coverage Provisions, Hospitalization and general anesthesia for dental procedures for dependent children, effective September 1, 1998, states:

- (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; and
  - (II) Require that if coverage is provided through a managed care plan, the benefits mandated pursuant to this subsection (12) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the carrier; and

(III) Restrict coverage to include anesthesia provided by an anesthesia provider only during procedures performed by an educationally qualified specialist in pediatric dentistry or other dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

(c) The provisions of this subsection (12) shall not apply to treatment rendered for temporal mandibular joint (TMJ) disorders.

The Company has not provided for the mandated coverage of dental anesthesia for dependent children by amendment of existing plans, inclusion of such benefits in the Certificates of Coverage issued subsequent to the effective date of the law, or provision of advice to Members of the availability of such benefits in the “Colorado Member Bulletin No. 1 for 1999.”

The Company’s Certificates of Coverage specifically exclude such coverage by stating:

Exclusions and Limitations

- *Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth [emphasis added], dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, and dental implants are not covered. This exclusion does not include [bony impacted teeth,] bone fractures, removal of tumors, and orthodontogenic cysts (sic).*

The examiners note that treatment of bone fractures is covered in the Certificates of Coverage dated May and October 1998 but is not covered in the Certificate of Coverage dated March 1997 or in the Basic and Standard Plan Certificate of Coverage dated January 1998, both of which omit the last sentence above.

Contract

Form Number

Certificate of Coverage  
Certificate of Coverage  
Certificate of Coverage  
Certificate of Coverage

HMO/CO-SG COC-2 01/98  
HMO/CO COC-1 03/97  
HMO/CO COC-2 05/98  
HMO/CO COC-3 10/98

**Recommendation No. 33:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104(12), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all forms to provide the mandated dental anesthesia benefits for dependent children. The Company should work with the Division of Insurance to ensure that no Member was denied benefits for dental anesthesia.

**Issue E25: Failure to provide for the mandated coverage of diabetes equipment, supplies, and self-management education.**

Section 10-16-104(13), C.R.S., Mandatory Coverage Provisions, Diabetes, effective July 1, 1998, states:

- (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 diabetes that shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items pursuant to Colorado law, and, if coverage is provided through a managed care plan, such qualified provider shall be a participating provider in such managed care plan.
- (b) Diabetes outpatient self-management training and education when prescribed shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.
- (c) The benefits provided in this subsection (13) are subject to the same annual deductibles or copayments established for all other covered benefits within a given policy.

The Company has not provided for the mandated coverage of diabetes equipment, supplies, and self-management education, by amendment of existing plans, or inclusion of such benefits in the Certificate of Coverage dated subsequent to the effective date of the law, and did not provide notice to Members of the availability of such benefits until it issued the “Colorado Member Bulletin No.1 for 1999” in which it stated that coverage would be provided immediately, instead of the effective date of the law.

The Company’s Certificates of Coverage state:

Exclusions and Limitations

A. Exclusions.

- Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as *syringes*, incontinence pads, elastic stockings, and *reagent strips*.
- Specific injectable drugs, including:
  - 2. *needles, syringes and other injectable aids*;  
[Emphases added.]

<u>Contract</u>	<u>Form Number</u>
Certificate of Coverage	HMO/CO COC-1 03/97
Certificate of Coverage	HMO/CO COC-2 05/98
Certificate of Coverage	HMO/CO COC-3 10/98

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**Recommendation No. 34:**

Within 30 days the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-104(13), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to provide for the mandated diabetic coverage.

**UNDERWRITING  
RATING  
FINDINGS**

**Issue F1: Failure to charge rates as filed.**

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

- (2) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 and *copies of the rates and classification of risks or subscribers pertaining thereto are filed with the commissioner.* [Emphasis added.]

The Company was not in compliance with the requirements of Colorado law in that the rates charged for small group plans that were issued during the fourth quarter of 1998, differed from the rates filed with the commissioner.

The examiners selected a sample of ten (10) small group plans that were issued during 1998, to determine if the rates filed with the commissioner matched the rates actually charged by the Company. Four (4) of the ten (10) groups in the sample were issued during the fourth quarter of 1998. In all four cases, the actual rates charged were not the rates as filed.

According to information provided in a February 2, 2000, memorandum from the Company, an incorrect RX base rate was listed in the Company's rate manuals.

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**Recommendation No. 35:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that the rates being charged are the rates filed with the Division of Insurance.

**UNDERWRITING  
APPLICATIONS  
FINDINGS**

**Issue G1: Failure to state on application and renewal forms that the Employer is entitled to a choice of composite rates or four-tier family, age banded rates and to see what the premium would be quoted either way.**

Regulation 4-6-7(VI), Concerning Premium Rate Setting for Small Group Health Plans, Use of Composite Rates, promulgated under the authority of Sections 10-1-109(1), 10-16-105(6.5), 10-16-105(7.2), 10-16-105(8)(f), and 10-16-109, C.R.S., states:

- A. Small employer carriers may offer small employers composite rates as an alternative to four-tier family, age-banded rates calculated pursuant to Section 5 of this regulation if all of the following conditions are met:
- (5) The small employer carrier must clearly state on all its application and renewal forms for all its small group products that employers with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates, and have the right to see what the premium would be quoted either way. Such materials shall also clearly explain the differences between the two rating approaches.

Colorado law requires that if the carrier chooses to offer composite rates to groups of ten or more, it must also provide the Employer with a choice of four-tier family, age-banded rates, and must state on all its small group application and renewal forms that the employer has the right to see what the premium would be, quoted either way.

The examiners requested a systematically selected sample of fifty (50) files from a population of 2,012 application/policy files. Of the fifty (50) files, three (3) were large National Group Accounts, and one (1) file could not be produced, thus reducing the reviewed sample to forty-six (46) files. The examiners could not locate the required disclosure statement or explanation in any of the files.

**DISCLOSURE STATEMENT**

Population	Sample Size	Number of Exceptions	Percentage to Sample
2012	46	46	100%

**Recommendation No. 36:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-7(VI). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its application and renewal forms to provide the required disclosure statement.

**Issue G2: Failure to state on application and renewal forms the required disclosure statement regarding rate setting and premium impact.**

Regulation 4-6-8(9), Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5 (8), 10-16-109, and 10-16-214(1)(d), and 10-16-708, C.R.S., states:

Disclosure requirements

A. Pursuant to Sections 10-16-105(5), as amended by Senate Bill 97-54, and 10-16-704(9), C.R.S., small employer carriers shall provide, on all printed marketing and solicitation materials for their small group health products and in a separate boxed section with bold type no less than twelve (12) point, a clearly written disclosure that:

- (1) Identifies the class of business;
- (2) Specifies case characteristics and rating factors used in setting new and renewal rates and the extent to which they impact premiums;
- (3) Explains the employer's right to renew;
- (4) Explains pre-existing condition exclusions;
- (5) Discloses that rates for any and all small group products being marketed by the carrier in the Colorado small group market will be given to a small employer, upon either oral or written request of such employer, within five (5) working days of the request; and
- (6) In the case of a managed care plan, on and after January 1, 1998, explains the existence, availability and general nature of an access plan, (e.g., that an access plan exists for every managed care plan and that it lists hospitals, providers, referral procedures, grievance procedures and emergency coverage provisions).

B. Small employer carriers also shall include in all printed marketing and solicitation materials information as to the benefits and premiums available under all health benefit plans for which the employer is qualified, pursuant to Section 10-16-105(5), C.R.S., as amended by Senate Bill 97-54. This requirement shall be satisfied if the carrier provides the following information:

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

- (2) A summary of the benefits available under all the plans for which the employer qualifies which highlights the most salient differences among the plans.

The examiners requested a systematically selected sample of fifty (50) files from a population of 2,012 application/policy files. Of the fifty (50) files, three (3) were large National Group Accounts, and one (1) file could not be produced, thus reducing the reviewed sample to forty-six (46) files. The examiners could not locate the disclosure requirements on any solicitation materials in the files.

**DISCLOSURE STATEMENT**

Population	Sample Size	Number of Exceptions	Percentage to Sample
2012	46	46	100%

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**Recommendation No. 37:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-8(9). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its solicitation materials to include the required disclosure statement.

**Issue G3: Failure to obtain correct waivers of coverage.**

Regulation 4-6-8(5)(B)(4), Concerning Small Employer Health Plans, Issuance of Coverage, Determining Who is an Eligible Employee, Dependent, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5 (8), 10-16-109, and 10-16-214(1)(d), and 10-16-708, C.R.S., states:

A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an eligible employee (or each employer-determined eligible employee and their dependents if this is different than the list of eligible employees) who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage (e.g., covered under spouse's plan, can't afford coverage, etc.) be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for all active employees.

The examiners requested a systematically selected sample of fifty (50) files from a population of 2,012 application/policy files. Of the fifty (50) files, three (3) were large National Group Accounts, and one (1) file could not be produced, thus reducing the reviewed sample to forty-six (46) files. Seven (7) of the files that should have included waivers of coverage did not contain the waivers specified in the Regulation. Instead, Enrollment Forms marked WAIVED were used. The forms did not contain the reason for declining coverage and did not have an explanation of the penalties imposed on late enrollees.

**WAIVERS OF COVERAGE**

Population	Sample Size	Number of Exceptions	Percentage to Sample
2012	46	7	15%

**Recommendation No. 38:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-8(5)(B)(4). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that waiver forms for declining coverage, as required by law, are received.

**Issue G4: Failure to obtain census data.**

Regulation 4-6-8(5)(B)(3) Concerning Small Employer Health Plans, Issuance of Coverage, Determining Who is an Eligible Employee, Dependent, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5 (8), 10-16-109, and 10-16-214(1)(d), and 10-16-708, C.R.S., states:

A small employer carrier shall require each small employer that applies for coverage with an effective date on or after January 1, 1995, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list. The small employer carrier may require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.

The examiners requested a systematically selected sample of fifty (50) files from a population of 2,012 application/policy files. Of the fifty (50) files, three (3) were large National Group Accounts, and one (1) file could not be produced, thus reducing the reviewed sample to forty-six (46) files. Thirteen (13) files, which had more than one (1) eligible employee, did not contain complete lists of eligible employees and their dependents.

**CENSUS INFORMATION**

Population	Sample Size	Number of Exceptions	Percentage to Sample
2012	46	13	28%

**Recommendation No. 39:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-8(5)(B)(3). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that a complete list of eligible employees and dependents of eligible employees is obtained upon submission of a Small Group application.

**Issue G5: Failure to comply with law when using age-banded vs. composite rates for Small Employers.**

Regulation 4-6-7(VI), Concerning Premium Rate Setting for Small Group Health Plans, Use of Composite Rates, promulgated under the authority of Sections 10-1-109(1), 10-16-105(6.5), 10-16-105(7.2), 10-16-105(8)(f), and 10-16-109, C.R.S., states:

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

(5) The small employer carrier must clearly state on all its application and renewal forms for all its small group products that employers with *ten (10) or more* [emphasis added] eligible employees are entitled to a *choice* [emphasis added] of composite rates or four-tier family, age-banded rates, and have the right to see what the premium would be quoted either way. Such materials shall also clearly explain the differences between the two rating approaches.

Colorado law requires that if the carrier chooses to offer composite rates vs. four-tier family, age-banded rates, it shall offer it to groups of ten (10) or more, giving the small group employer a choice.

During the review of the application files, the examiners noted that:

1. The Company incorrectly issued policies with age-banded rates for groups of one (1) to ten (10), rather than one (1) to nine (9) eligible employees, and composite rates for groups of eleven (11) to fifty (50), rather than ten (10) to fifty (50) eligible employees.
2. The Company did not offer the choice between composite and four-tier family age-banded rates, but automatically used composite rates for groups of eleven (11) to fifty (50) eligible employees.

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**Recommendation No. 40:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-7(VI). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its applications to ensure that rates are offered and provided according to law.

**Issue G6: Failure to Observe the Plan Sponsor's Right to Choose the Length of the Waiting Period.**

Section 10-16-102(45), Health Care Coverage, Definitions, states:

“Waiting period” means, with respect to a group health benefit plan and an individual that is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual, *as determined by the plan sponsor* [emphasis added], before the individual is eligible to be covered for benefits under the terms of the plan.

The Company was not in compliance with Colorado insurance law in that the Company's Small Group Proposal Form states:

Benefit Waiting Period (BWP)

Standard BWP is 3 months minimum, 6 months maximum or match the incumbent carrier's BWP up to 6 months maximum.

These forms require the employer to sign and date the acknowledgment of the Small Group proposal Form.

The waiting period for employees is at the sole discretion of the plan sponsor.

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**Recommendation No. 41:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102(45), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Small Group Proposal Forms to specify that the plan sponsor has the right to determine the employee waiting period.

**Issue G7: Failure to correctly state the age limit for dependent students.**

Section 10-16-102(14), C.R.S., Definitions, states:

“Dependent” means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

The Employer Application Forms incorrectly stated:

Standard: dependents up to age 19, *students to age 23* [emphasis added].

From a population of 2,012 application files, examiners systematically selected fifty (50) files for review. Of the fifty (50) selected three (3) were large National Group Accounts, and one (1) file could not be produced thus reducing the sample size to forty-six (46). The examiners reviewed the forty-six (46) files provided. In all but four (4) files the incorrect age appeared on the application forms.

APPLICATION FILES

Population	Sample Size	Exceptions	Percentage of error
2012	46	42	91%

The incorrect age for students also appeared on the Proposal Forms located in these files, and similar language was found on the Schedule of Benefits during the review of the Company’s forms.

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**Recommendation No. 42:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102(14), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all forms to correctly define dependent.

**Issue G8: Failure to correctly define eligible employee.**

Section 10-16-102(15), C.R.S., Definitions, states:

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

Section 10-16-105(7)(a), C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

Effective January 1, 1995, if a small employer carrier offers coverage to a small employer, such small employer carrier shall offer the same coverage to all of the eligible employees of the small employer and their dependents. A small employer carrier shall not offer coverage to only certain eligible individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in section 10-16-118(1)(c).

Regulation 4-6-8(5)(B)(2), Concerning Small Employer Health Plans, Issuance of Coverage, Determining Who is an Eligible Employee, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214(1)(d), and 10-16-708, C.R.S., states:

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

From a population of 2,012 application files, examiners systematically selected fifty (50) files for review. Of the fifty (50) selected, three (3) were large National Group Accounts, and one (1) file could not be provided, thus reducing the sample size to forty-six (46). The examiners reviewed all forty-six (46) files provided.

All of the Employer Application Forms reviewed have the following:

6. Employee Eligibility

Active full-time working a minimum of 30 hrs./wk.

APPLICATION FILES

Population	Sample Size	Exceptions	Percentage of error
2012	46	46	100%

Colorado insurance law defines the term “eligible employee,” which does not include an actively-at-work requirement. In the case of eligible employees, the only question is whether or not the employee has a regular work week of 24 or more hours. The actively-at-work eligibility requirement was also found on the Certificates of Coverage during the review of the Company’s forms.

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**Recommendation No. 43:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-102(15), 10-16-105(7)(a), C.R.S., and Regulation 4-6-8(5)(B)(2). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all application forms to correctly define the work requirement for an eligible employee

**UNDERWRITING  
CANCELLATIONS/NON-RENEWALS/DECLINATIONS  
FINDINGS**

**Issue H1: Failure to offer the Basic and Standard Plans upon termination of the group plan or upon termination of an enrollee's coverage under the group plan, and failure to maintain records of offers.**

Section 10-16-108(4), C.R.S., Conversion and Continuation privileges, Special provisions for small group health benefit plans, states:

- (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* [emphasis added] 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.
- (c) Each small employer carrier shall offer the choice of a basic or standard health benefit plan to any individual who loses nexus to existing small group coverage; except that:
  - (I) If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of this paragraph (c) shall not apply to such an individual; and
  - (II) If an individual lost nexus to group coverage for fraud or abuse in procuring or utilizing coverage, then the provisions of this paragraph (c) shall not apply to such an individual.

Regulation 1-1-7(III)(B)(1), Market Conduct Record Retention, promulgated under the authority of Section 10-1-109, C.R.S., states:

Every insurer/carrier or related entity licensed to do business in this state shall maintain its books, records, documents and other business records so that the insurer's/carrier's or related entity's claims, rating, underwriting, marketing, complaint, and producer licensing records are readily available to the commissioner. Unless otherwise stated within this regulation, records shall be maintained for the current year plus two calendar years.

As part of the review of canceled/terminated small group plans, the examiners requested copies of offers, if applicable, of conversion policies.

The Company was not in compliance with the above Colorado insurance laws during the examination period of 1998 for the following reasons:

- The Company could not supply copies of any conversion offers made to eligible individuals.

- The Company stated that it did not keep copies of offers. The Company cannot document or substantiate that offers were made.
  - In the Company's 1998 Colorado Small Group Activity Report filed with the Division of Insurance, the Company reported that they did not issue any conversion plans to individuals terminating from small group plans in 1998.
  - The Company could not supply a copy of either a basic or a standard conversion plan available for use during the examination period.
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**Recommendation No. 44:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108(4) and Regulation 1-1-7(III)(B). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that the Basic and Standard plans are offered upon termination from group coverage, and that records of these offers are maintained.

**Issue H2: Failure to maintain cancellation/termination records.**

Regulation 1-1-7(III)(B)(1), Market Conduct Record Retention, Rule, Records Required For Market Conduct Purposes, promulgated under the authority of Section 10-1-109, C.R.S., states:

Every insurer/carrier or related entity licensed to do business in this state shall maintain its books, records, documents and other business records so that the insurer's/carrier's or related entity's claims, rating, underwriting, marketing, complaint, and producer licensing records are readily available to the commissioner. Unless otherwise stated within this regulation, records shall be maintained for the current calendar year plus two calendar years.

**SMALL GROUP CANCELLATION/TERMINATION FILES**

Population	Sample Size	Number of Exceptions	Percentage to Sample
49	49	18	37%

The examiners reviewed the entire population of forty-nine (49) small group plans that had coverage terminated during the examination period.

Eighteen (18) files were missing the information required to verify the reasons for termination.

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**Recommendation No. 45:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 1-1-7(III)(B)(1). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that records are maintained as required by law.

**Issue H3: Failure to terminate small group coverage in a consistent manner and consistent with law.**

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

*Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever; [Emphases added.]*

Section 10-16-102(26), C.R.S., Health Care Coverage, Definitions, effective July 1, 1997, states:

“Late enrollee” means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual:

(III) Requests enrollment within thirty days after termination of the other creditable coverage; or

(a) A person becomes a dependent of a covered person through marriage, birth, adoption, or placement for adoption and requests enrollment no later than thirty days after becoming such a dependent. In such case, coverage shall commence on the date the person becomes a dependent if a request for enrollment is received in a timely fashion before such date.

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

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

(b) Shall waive any affiliation period or time period applicable to a pre-existing 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.

Regulation 4-2-18(V), Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions, Rules, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109, and 10-16-118(1)(b), C.R.S., as amended by Senate Bill 97-54, states in part:

B. Exception: Minimum ninety (90) day gap for creditable coverage

Colorado law requires health coverage plans to waive any exclusionary time periods applicable to a pre-existing 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 date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.

The examiners reviewed the entire population of forty-nine (49) small group plans that were terminated during the examination period. There were twenty-six (26) plans subject to retrospective termination due to non-payment of premiums.

SMALL GROUP CANCELLATION/TERMINATION FILES

Population	Sample Size	Number of Exceptions	Percentage to Sample
49	49	26	53%

These small groups were inconsistently terminated resulting in unfair discrimination. Retrospectively terminating a group may result in adverse treatment of enrollees. For example:

1. *Change in family status* (marriage, birth or adoption). The employee has 31 days from the date of the change in family status in which to enroll himself and his dependents.

An employee who initially declined coverage for himself and who marries on February 1 has 31 days to apply for enrollment for himself and his spouse. If he applies for enrollment under his group's plan and is accepted by the group but the group has not paid the premium since January 1, and the Company advises the group on July 1 that it is terminated retrospectively to January 31, the 31 day Special Enrollment Period during which his spouse could have enrolled him under her plan has passed and the employee and his spouse if she did not enroll in her employer's plan may thus:

- Be considered late enrollees under his spouse's plan;
- Have a gap of more than 90 days in coverage;
- Be denied credit for any pre-existing conditions limitation under the spouse's plan.

2. *Loss of coverage due to termination of the employer's contribution towards the coverage.* The employee has 31 days from the date of loss of coverage in which to enroll himself and his dependents under his spouse's employer's plan. If notification of his group plan's termination is retroactive as in the example above, the employee and his dependents may be considered late enrollees under the spouse's plan and experience the same penalties as noted in 1. above.

3. *Loss of qualification as an “eligible Individual” under federal law.* An individual who has lost his COBRA coverage and who has 18 months of creditable coverage, the most recent of which was under an employer’s plan, must be permitted to enroll in individual coverage if he timely enrolls. By retrospectively terminating the group, the enrollee and his dependents may not be aware for sometime that they have lost their COBRA coverage and may be denied guaranteed issue of an individual health care contract (i.e. coverage without medical underwriting and with credit for pre-existing conditions limitations) because they did not timely apply for such individual coverage.
4. *Claims processing.* The enrollee may incur claims believing in good faith that he or she had health coverage, only to find that he or she is liable for those medical costs.

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**Recommendation No. 46:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104(1)(f)(II), 10-16-102(26), 10-16-118, C.R.S. and Regulation 4-2-18(V)(B). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that small group terminations are processed in a timely manner, and consistent with law.

**CLAIMS**  
**FINDINGS**

**Issue J1: Failure to accurately process claims.**

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

*Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever [Emphases added.];*

Section 10-3-1104(1)(h), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

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:

- (IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information; . .
- (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; . .

**PAID CLAIMS SAMPLE**

Population	Sample Size	Number of Exceptions	Percentage to Sample
33,152	100	45	45%

**DENIED CLAIMS SAMPLE**

Population	Sample Size	Number of Exceptions	Percentage to Sample
27,748	100	16	16%

Systematically selected samples of 100 paid claims and 100 denied claims were reviewed.

The following claims received from January 1, 1998, through December 31, 1998, contained errors that resulted in underpayments or overpayments, or could have affected the processing of other claims. As these claims were not processed accurately, it resulted or could have resulted in the unfair and inconsistent treatment of the Members.

To summarize:

1. Thirty-three (33) claims from the paid sample, and seven (7) claims from the denied sample involved payments made to providers for amounts other than their contracted or capitated rates. Most of the incorrect payments appeared to have been made due to provider contracts not being loaded onto the system in a timely manner and then entering the effective date of the contract retroactively.
2. Two (2) claims from the paid sample were processed on the wrong provider.
3. Five (5) claims from the paid sample, and two (2) claims from the denied sample involved services either paid incorrectly, paid in error, paid twice, or inappropriately denied.
4. Inappropriate remit codes were used on two (2) of the paid claims informing the provider they were paid a reasonable and equitable fee instead of their contracted rate.
5. One (1) claim from the paid sample involved an incorrect reimbursement to a non-participating provider.
6. One (1) claim from the denied sample was processed on the wrong family member.
7. Two (2) claims from the paid sample appear to have been delayed due to failure to investigate the correct provider and the correct address once the incorrect payments were returned. One of these claims, over a year later, is still partially unresolved.
8. One (1) claim from the denied sample was processed without coordination of benefits with other insurance.
9. Incorrect copays were deducted on three (3) claims from the denied sample.
10. Services were not processed together causing incorrect rebundling of procedures on two (2) claims from the denied sample.

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**Recommendation No. 47:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104(1), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure accurate processing of claims.

**Issue J2: Failure to pay eligible charges.**

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

Section 10-3-1104(1)(h)(IV), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

Refusing to pay claims without conducting a reasonable investigation based upon all available information; . .

From a population of 27,748 claims received and denied from January 1, 1998, through December 31, 1998, a systematically selected sample of 100 claims was reviewed.

**DENIED CLAIMS SAMPLE**

Population	Sample Size	Number of Exceptions	Percentage to Sample
27,748	100	7	7%

At the time they were denied, the Company was in possession of the information it needed to properly adjudicate the claims. This resulted in unfair and inconsistent treatment of members as follows:

1. One claim from the denied sample was processed under the subscriber instead of the dependent, which resulted in denial of the services on the basis that the treating physician was not the correct Primary Care Physician.
2. A claim from the denied sample was for allergy treatment from a specialist and was incorrectly denied due to lack of a referral. The records indicate the Member's Primary Care Physician had authorized the services, but the referral was not entered into the Company's system until after the claim was processed.
3. A claim from the denied sample was from a Participating Primary Care Physician and was incorrectly denied due to lack of a referral. The records indicate the member did not have a Primary Care Physician assigned at the time the claim was processed. Therefore, the claim should have been denied due to non-assignment of a Primary Care Physician, rather than lack of a referral.
4. A claim from the denied sample included a charge for a "fetal non-stress test" that was incorrectly denied on the basis that the procedure was not included on a referral. Authorization for this procedure was included in the referral that was written for the Member's maternity care.

5. A claim from the denied sample was incorrectly denied when it was processed under an incorrect (terminated) Member's ID, rather than the correct Member's ID.
6. A claim from the denied sample was processed with an incorrect provider ID, which resulted in an incorrect denial of a physician office visit on the basis the provider was not the Member's Primary Care Physician.
7. A claim from the denied sample for a Primary Care Physician office visit was incorrectly denied due to a delay in changing the primary care office assigned to the Member.

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**Recommendation No. 48:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104(1), C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its quality controls to ensure that the processing staff is properly trained to make appropriate decisions and thus avoid denying eligible claims.

**UTILIZATION REVIEW  
FINDINGS**

**Issue K1: Failure to provide the notification of decision on first level appeals within the required time frame.**

Regulation 4-2-17(8), Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to Sections 10-1-109, 10-3-1107, 10-3-1110, and 10-16-109, C.R.S., states:

I. Standard Appeals

A. First Level Appeal Review

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal . . . .

The examiners were provided fourteen (14) files that the Company had identified as the total population of first level utilization review appeals received during the examination period. The examiners reviewed the entire population. In eight (8) of the files, the notification of decision was not sent within the twenty (20) working days as required by law.

FIRST LEVEL APPEALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
14	14	8	57%

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**Recommendation No. 49:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-2-17(8)(I)(A). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed its procedures and implemented appropriate changes to ensure that the notification of decisions involving first level appeals are sent within the time frame specified by law.

**Issue K2: Failure to advise in acknowledgement letters, the correct time frame as allowed by law to make a decision involving a first level appeal.**

Section 10-3-1104(1)(b), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

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;

Regulation 4-2-17(8), Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to Sections 10-1-109, 10-3-1107, 10-3-1110, and 10-16-109, C.R.S., states:

I. Standard Appeals

A. First Level Appeal Review

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal

....

The examiners were provided fourteen (14) files that the Company had identified as the total population of first level utilization review appeals received during the examination period. The examiners reviewed the entire population. In eight (8) of the files, the acknowledgment letter sent to the Member stated that the Company hoped to resolve the matter within thirty (30) days instead of twenty (20) working days as required by law.

FIRST LEVEL APPEALS ACKNOWLEDGMENT LETTERS

Population	Sample Size	Number of Exceptions	Percentage to Sample
14	14	8	57%

**Recommendation No. 50:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104(1)(b), C.R.S. and Regulation 4-2-17(8)(II)(B). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed its procedures and implemented appropriate changes to ensure that members are informed correctly of the time frame, as specified by law, in which their appeals will be resolved.

**Issue K3: Failure to include all of the information required by law in the notification of an adverse decision involving first level appeals.**

Regulation 4-2-17(8), Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to Sections 10-1-109, 10-3-1107, 10-3-1110, and 10-16-109, C.R.S., states:

I. Standard Appeals

A. First Level Appeal Review

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. The written decision shall contain:
  - a) The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called “the reviewers.”);

The examiners were provided fourteen (14) files that the Company had identified as the total population of first level utilization review appeals received during the examination period. The examiners reviewed the entire population. The notification of adverse decision did not contain all of the information as required by law in six (6) of the fourteen (14) files reviewed.

**ADVERSE DECISION NOTIFICATION LETTERS**

Population	Sample Size	Number of Exceptions	Percentage to Sample
14	14	6	43%

**Recommendation No. 51:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-2-17(8)(I)(A)(3). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed its procedures and implemented appropriate changes to ensure that all notifications of adverse decision contain all of the information required by law to be provided to Members.

**Issue K4: Failure to inform Members of their rights as required by law in second level appeal letters.**

Regulation 4-2-17(8), Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to Sections 10-1-109, 10-3-1107, 10-3-1110, and 10-16-109, C.R.S., states:

II. Standard Appeals

B. Second Level Appeal Review

4. A health carrier's procedure for conducting a second level panel review shall include the following:
  - c) A covered person has the right to:
    - (3) Submit supporting material both before and at the review meeting;
    - (4) Ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing; and
    - (5) Be assisted or represented by a person of his or her choice.
  - d) The notice shall advise the covered person of the rights specified in this section 8.I.B;

The Company received one (1) second level appeal during the examination period. The second level appeal procedures are more restrictive than permitted by law in that the letter sent to the member prior to the review panel meeting states:

1. In addition, you will have fifteen minutes to make a verbal presentation, if you like.

The law allows a person to present his case to the panel in person and ask any questions of the panelists at the hearing. Nothing in the law limits the member to only fifteen (15) minutes.

2. You may invite whomever wish to the hearing; however, they will not be able to question panel members.

A member has the right to be assisted or represented by a person of his choice. This includes the right to question panel members.

3. If you wish to add additional information, please forward to me by July 13<sup>th</sup>.

Although it is helpful for a member to submit additional information prior to the meeting, the Member should be made aware that supporting information might also be submitted at the review meeting.

In addition, the Company received one (1) second level appeal during the examination period. It appears that the Member was not notified of the review meeting in the time frame set forth in the Complaint Process letter. The Company's Complaint Process letter states:

As stated in your HMO Certificate of Coverage

**SUMMARY OF THE PROCEDURE:**

Step 3 -- . . .The Representative will notify you of the time, date and place where the hearing will be conducted within 5 working days after receiving a request for a hearing . . .

The Member requested a grievance hearing in writing, which was received by the Company June 19, 1998. The Company notified the Member of the time, date and place of the review meeting, on July 6, 1998, eleven (11) working days later.

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**Recommendation No. 52:**

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-2-17(8). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed its procedures and implemented appropriate changes to ensure that members are informed of their rights at a second level appeal as provided by law.

**SUMMARY OF ISSUES AND RECOMMENDATIONS**

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<b>Failure to provide enrollees with a statement of financial condition.</b>	2	20
<b>Failure to specify in provider contracts that the provider is solely responsible for obtaining preauthorization.</b>	3	21
<b>Failure to accurately reflect in provider contracts the required provisions for continuity of care.</b>	4	25
<b>MARKETING AND SALES – FINDINGS</b>		
<b>Failure to correctly reflect on the Colorado Health Benefit Plan Description form, the benefits required to be provided under the Colorado Basic and Standard Plans.</b>	5	38
<b>Failure to timely file a Certificate of Compliance.</b>	6	39
<b>Failure to disclose on all marketing materials, the existence, availability, and general nature of the Company's access plan.</b>	7	41
<b>Failure to include the disclosure requirements of Regulation 4-6-8 on all marketing materials.</b>	8	43
<b>COMPLAINTS – FINDINGS</b>		
<b>Failure to record on the Company's complaint log, all complaints received.</b>	9	46
<b>UNDERWRITING – CONTRACT FORMS - FINDINGS</b>		
<b>Failure to provide correct information on enrollment materials concerning coverage of prescription drugs under a converted contract.</b>	10	50
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<b>Failure to exclude actively-at-work status, and non-confinement status as conditions for eligibility of enrollees.</b>	12	57
<b>Failure to correctly reflect the benefits required to be provided under the Colorado Basic and Standard Plans.</b>	13	61
<b>Failure to provide for coverage of emergency services unless the Company retrospectively determines that an emergency existed.</b>	14	64
<b>Failure to limit reasons for termination of state continuation coverage to those permitted by law.</b>	15	66
<b>Failure to provide correct information concerning eligibility for conversion coverage.</b>	16	69
<b>Failure to provide for continuation of coverage for a Member who is an inpatient on the date of contract termination, until release from the facility.</b>	17	71
<b>Failure to cover some services and supplies required to be covered under the Basic and Standard Plans.</b>	18	74
<b>Failure to correctly cover complications resulting from non-covered services.</b>	19	76
<b>Failure to cover serious mental illnesses prior to exhaustion of benefits for other than serious mental illnesses, and to amend plans to provide the mandated coverage for serious mental illnesses.</b>	20	79

**Market Conduct Examination  
Summary of Issues/Rec's. Locator**

**Aetna U.S. Healthcare Inc.**

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<b>Failure to Include the Mandatory Disclosure Statement on Small Group Application Forms.</b>	22	82
<b>Failure to state correctly in Membership Certificates that the Open Enrollment Period is a period of at least one month.</b>	23	84
<b>Failure to provide full and correct information concerning Special Enrollees.</b>	24	88
<b>Failure to comply with the required procedures for utilization review.</b>	25	94
<b>Failure to file forms in accordance with law and to maintain records of filings.</b>	26	96
<b>Failure to uniformly provide for first level appeal decision notification within twenty (20) working days.</b>	27	98
<b>Failure to conform Group Agreements and Service Agreements to the requirements of law concerning contract terminations.</b>	28	101
<b>Failure to conform Service Agreements to the requirements of law concerning dependent eligibility.</b>	29	103
<b>Failure to provide for conversion coverage of all medically certified disabled dependents by restricting the conversion privilege to a developmentally disabled or physically handicapped dependent.</b>	30	105
<b>Failure to provide Coordination of Benefits as required by law.</b>	31	109
<b>Failure to maintain records.</b>	32	110
<b>Failure to provide for the mandated dental anesthesia benefits for dependent children.</b>	33	113
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<b>Failure to state on application and renewal forms that the Employer is entitled to a choice of composite rates or four-tier family, age banded rates and to see what the premium would be quoted either way.</b>	36	119
<b>Failure to state on application and renewal forms the required disclosure statement regarding rate setting and premium impact.</b>	37	121
<b>Failure to obtain correct waivers of coverage.</b>	38	122
<b>Failure to obtain census data.</b>	39	123
<b>Failure to comply with law when using age-banded vs. composite rates for Small Employers.</b>	40	124
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**Market Conduct Examination  
Summary of Issues/Rec's. Locator**

**Aetna U.S. Healthcare Inc.**

<b>ISSUES</b>	<b>Rec. No.</b>	<b>Page No.</b>
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<b>Failure to include all of the information required by law in the notification of an adverse decision involving first level appeals.</b>	51	145
<b>Failure to inform Members of their rights as allowed by law in second level appeal letters.</b>	52	147

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