

MARKET CONDUCT EXAMINATION REPORT

AS OF DECEMBER 31, 1998

PRINCIPAL LIFE INSURANCE COMPANY

711 High Street

Des Moines, IA 50392-2300

NAIC Group Code 0332

NAIC Company Code 61271

**EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS FOR
COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE**

Donald R. Koelker, CIE, FLMI, AIRC, ALHC

Sue Howe, CIE

Lynn Zukus

Independent Market Conduct Examiners

Contracting with

The Colorado Division of Insurance

1560 Broadway, Suite 850

Denver, CO 80202

(303) 894-7499

February 24, 2000

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

Commissioner:

The market conduct examination of Principal Life Insurance Company was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-216, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine insurance companies. We examined the Company's records at its office located at 711 High Street, Des Moines, IA. The market conduct examination covered the period from January 1, 1998 through December 31, 1998.

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

Donald R. Koelker, CIE, FLMI, AIRC, ALHC

Sue Howe, CIE

Lynn Zukus

MARKET CONDUCT
EXAMINATION REPORT
OF
PRINCIPAL LIFE INSURANCE COMPANY

TABLE OF CONTENTS

SECTION	PAGE
I. COMPANY PROFILE	5
II. PURPOSE AND SCOPE OF EXAMINATION	6
III. EXAMINERS' METHODOLOGY	7
IV. EXAMINATION REPORT SUMMARY	10
V. FACTUAL FINDINGS.....	13
B. Marketing and Sales.....	14
C. Complaints.....	21
E. Underwriting - Policy Forms	24
F. Underwriting - Rating	57
H. Underwriting - Terminations / Declinations / Non-Renewals	64
J. Claims	69
VI. SUMMARY OF ISSUES AND RECOMMENDATIONS.....	78
VII. EXAMINATION REPORT SUBMISSION	80

COMPANY PROFILE

The Company provided the following information:

Principal Life Insurance Company is licensed to transact life, health, disability, and annuity business, and cover approximately 57,011 Colorado residents. The 1998 premium for small employer group premiums was \$32,977,438. The Company is active in issuing products, in all fifty states of the United States, the District of Columbia and Puerto Rico. The Company is licensed as a reinsurer only in Mexico.

The Principal Financial Group is a diversified family of companies offering a wide range of insurance and other financial products and services for businesses, groups and individuals. The Company serves approximately 10.1 million customers through the Des Moines, Iowa headquarters and a network of satellite offices and claims centers, agency, brokerage and sales offices, residential mortgage offices and subsidiaries. The flagship and the largest member, Principal Life Insurance Company ("Principal Life or The Principal") is currently the eighth largest U.S. life insurance company ranked by year-end 1997 asset figures.

Principal Life currently serves customers from offices in more than 250 locations worldwide, including offices in Europe, Asia, Latin America and the United States. In addition, to diverse geographic markets, the Company has major operations in group/employee benefits, pensions and individual insurance. Within the businesses, the Company has diverse product offerings and markets them in several ways to individuals, employers and their employees.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (DOI), in accordance with Sections 10-1-202, 10-1-203, and 10-1-204, Colorado Revised Statutes (C.R.S.) reviewed certain business practices of Principal Life Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The 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 laws and with generally accepted operating principles related to Colorado health care insurance 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, but was not limited to, review of the following:

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

The final examination 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 allows 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 governing the Company's products. 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 insurance company or insurance product.

EXAMINERS' METHODOLOGY

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

Exhibit 1

Law/Regulation	Concerning
Sections 10-1-127	Fraudulent Insurance Acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration
Sections 10-2-101 10-2-704	Colorado Single Insurance Producer Licensing Act
Sections 10-3-1101 10-3-1104	Unfair Competition – Deceptive Practices
Sections 10-8-601 - 10-8-605	Small Employer Health Insurance Availability Program Act
Sections 10-16-101- 10-16-121 10-16-201 10-16-219	Colorado Health Care Coverage Act: Part I: Short Title – Definitions and General Provisions; Part 2: Sickness and Accident Insurance
Sections 10-16-701 10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans.
Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Automobile Private Passenger Forms, and Claims-made Liability Forms
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 4-2-7	Concerning the 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 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Regulation 4-2-18	The Method Of Crediting & Certifying Creditable Coverage For Pre-Existing Conditions.
Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
Regulation 4-6-2	Concerning Guidelines for Coordination of Benefits
Regulation 4-6-5	Implementation of Basic and Standard Health Plans
Regulation 4-6-7	Concerning Premium Rate Setting For Small Group Health Plans

Regulation 4-6-8	Concerning Small Employer Health Plans
Regulation 5-2-3	Auto Accident Reparations Act (No-Fault) Rules and Regulations
Regulation 6-1-1	Limiting Coverage
Regulation 6-2-1	Complaint Record Maintenance

Company Operations/Management

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

Anti-Fraud Plan; Disaster Recovery Plans Audits and Examinations

Principal Life Insurance Company filed its Fraud Management program with the State of Colorado in May 1994. The Company states the program is updated annually with the last revision being made in 1998.

Marketing and Sales

The examiners reviewed marketing, sales, and advertising materials for language that does not accurately represent products and that could be untrue, deceptive or misleading with respect to the offering of small group health benefit plans in Colorado. The examiners attempted to determine if Principal Life Insurance Company had methods of control over advertising content; verified the submission of the Certificate of Compliance which is to be filed annually with the Colorado Division of Insurance; and reviewed compliance with disclosure requirements used in solicitation of individual and small group health plans.

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 reviewed the Member Appeal Process and the Appeal/Complaint Resolution Process. The examiners also evaluated the Company's complaint handling methodology and reviewed the reason for and disposition of complaints.

Producers

A review was conducted of producers' license and appointment forms during the period under examination to determine whether producers were authorized to solicit business and receive compensation. The producer lists provided by the Company and the Division of Insurance were also reviewed to determine if the termination of producers was in compliance with applicable statutes and regulations.

Policy Forms

The examiners obtained and reviewed small group policy forms that were certified with the Colorado Division of Insurance (DOI) between January 1, 1998 and December 31, 1998. The examiners reviewed forms most commonly used by the Company to issue health insurance plans. The following are the policy forms reviewed:

- Accident and Health (Small Groups)
- Basic and Standard Health Benefit Plans

Rating

Colorado Division of Insurance actuaries reviewed Small Group rates and rating methodology, rate filings and supporting material, provided by the Company, to determine the acceptability of the Company's rates and rating methodology, and compliance with appropriate Colorado statutes and regulations.

Applications

The examiners reviewed the applications in a systematically selected sample of fifty (50) files out of 414 issued policies for Small Group plans during the period January 1, 1998 through December 31, 1998. One file was missing, thus reducing the small group sample for review to forty-nine (49) files.

Cancellations/Declinations/Non-Renewals/Terminations

Examiners reviewed the termination files in a systematically selected sample of fifty (50) out of 557 terminated policies for Small Group plans issued during the period of January 1, 1998 through December 31, 1998.

Claims

The examiner reviewed claims from a systematically selected sample of 200 files of Small Group and Individual Accident and Health plans. The claims were reviewed for the Company's overall claims handling practices to determine timeliness of payment, accuracy of processing, and entitlement to policy benefits.

Utilization Review

The examiners reviewed the Company's utilization management program including policies and procedures.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-eight (28) findings in which the Company was not in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Company Operations/Management:** The examiners found no areas of concern for Company Operations.
- **Marketing and Sales:** The examiners found three (3) areas of concern in their review of advertising materials.
 1. The Company's forms used in marketing small employer group policies did not contain the required Basic and Standard Plan disclosure statement.
 2. Failure to timely implement the Company's Comprehensive Health Benefit Plan Description Form for the state mandated Basic and Standard Health Benefit Plans and to ensure that the forms reflect the correct benefit levels.
 3. Failure to comply with disclosure statement requirements for printed marketing materials.

The examiners recommend that the Company implement procedures to ensure that all necessary marketing and training materials are in compliance with Colorado insurance law.

- **Complaints:** The examiners found one (1) area of concern in their review of complaints and procedures for the Company's handling and processing of complaints.
 1. The Company did not, in all cases, maintain a complete and accurate record of all consumer complaints received.

The examiners recommend that the Company revise its complaint tracking procedures to bring them into compliance with Colorado insurance law.

- **Producers:** The examiners found no areas of concern in their review of producers.
- **Policy Forms:** The examiners found thirteen (13) areas of concern in their review of the Company's contract forms (employer/employee applications, waiver forms, evidences of coverage and attached amendments). Examiners identified and summarized the issues as follows:
 1. Information in the policy forms did not comply with Colorado small employer insurance laws and regulations.
 2. Eligibility was conditioned on health status in some cases.
 3. Some policy forms contained provisions that were more restrictive than, or contrary to, regulatory requirements.

The examiners recommend that the Company review and revise policy forms to comply with Colorado insurance law and regulations.

- **Rating:** The examiners found six (6) areas of concern in their review of the rating documentation and methodology for Small Group and individual accident and health plans for the period of January 1, 1998 through December 31, 1998.
 1. The Company did not identify a unique Index Rate upon which the Company's small group rates must be based.
 2. The Company's rate filings consistently failed to provide adequate support, document or explain the development or selection for the underlying rating assumptions.
 3. The Company used an unnecessarily complicated version of the age band factors requirement in its small group rating methodology, which incorporated unacceptable rating variables.
 4. The Company incorrectly used a geographic location resulting in a rate filing containing an incorrect geographic factor.
 5. The Company failed to use rating variables, which were consistent with small group rating methodology.
 6. The Company failed to submit a composite rating methodology or to properly use composite rates when rating small group policies.

The examiners recommend that the Company review and revise its procedures to ensure accurate rate filings with the Division of Insurance, including its methodology and support of all rates charged for all products marketed and issued to Colorado residents.

- **Applications:** The examiners found no areas of concern.
- **Cancellations/Declinations/Termination:** The examiners found two (2) areas of concern in their review of cancellation and declinations files for the period January 1, 1998 through December 31, 1998.
 1. Failure to offer the employees the Basic or Standard Health Benefit Plan when small employer policies terminated.
 2. Company failed to provide a complete list of declined applications and action taken after declination.

The examiners recommend that the Company review and revise 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 three (3) areas of concern in their review of the claim handling practices of the Company.
 1. The date claims are received by the repricer is not available on the Company's claim system. Also, there are no controls in place to follow-up on requests for repricing information.
 2. Failure to consistently pay claims within the required sixty (60) days after receipt of a valid and complete claim and to properly investigate claims prior to payment or denial. This resulted in unnecessary delay in claim payment.
 3. Failure, in some cases, to accurately process claims.

The examiners recommend that the Company implement measures to accurately track the receipt date of a claim when it is being repriced. The Company should review its claim processing procedures and quality controls to ensure that they are adequate to minimize or prevent errors from recurring. The additional benefits due on all underpaid claims should be released in a timely manner. The Company should waive all overpayments identified in this review.

- **Utilization Review:** The examiners found no areas of concern.

FACTUAL FINDINGS

FOR

MARKET CONDUCT EXAMINATION REPORT

PRINCIPAL LIFE INSURANCE COMPANY

MARKETING AND SALES

Issue B1: Failure to include the correct disclosure statement on Small Employer marketing materials.

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., which was *in effect on November 1, 1997*, 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, 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."

Examiners reviewed a systematically selected sample of twenty-five (25) marketing material, twelve (12) brochures did not display the required disclosure statement in the format specified by 1998 Colorado insurance law.

The following Company forms contain disclosure wording different from that required by Regulation for examination period January 1, 1998 through December 31, 1998. The forms state:

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE 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.

DISCLOSURE STATEMENT			
Population	Sample Size	Number of Exceptions	Percentage to Sample
545	25	12	48%

Contract Form Name

Form Number

CO Designed Medical Indemnity Insurance Options Brochure, 08/97	GP39320-3
CO Designed medical PPO Insurance Options Brochure, 07/98	GP39321-3
PrinChoice Comprehensive Medical Insurance Brochure, 07/98	GP43298-2
PrinChoice Comprehensive Medical Insurance Brochure, 08/98	GP43298-3
IEA PrinChoice Indemnity PPO Insurance Brochure, 07/98	GP43299-2
IEA PrinChoice Indemnity Insurance Brochure, 08/98	GP43299-3
PrinChoice Indemnity PPO Brochure, 04/98	GP43300-1
PrinChoice Comprehensive Medical Insurance Brochure, 07/98	GP43300-2
PrinChoice Comprehensive Medical Insurance Brochure, 08/98	GP43300-3
Indemnity PPO Medical Proposal, 04/98	GP44666 CO
Indemnity PPO Medical Proposal, 08/98	GP44666-1 CO
Indemnity PPO Medical Proposal, 10/98	GP44666-2 CO

Recommendation No. 1:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-5(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 all marketing material to accurately provide the correct disclosure statement.

Issue B2: Failure to timely implement use of the Colorado Comprehensive Health Benefit Plan Description Form.

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

- A. Effective January 1, 1998, all carriers offering or providing health benefit plan coverage or Medicare supplement coverage shall make available a completed copy of the Colorado Health Plan Description Form shown in Appendix A for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer, except as provided in Section IV of this regulation.

- E. Carriers shall provide a Colorado Health Plan Description Form, which is specific with respect to the particular policy provisions of the policy it is marketing, selling, or has issued as follows:
 - 1. As part of its marketing materials, to any person who has expressed an interest in purchasing or obtaining coverage under a particular plan;
 - 2. Upon request when a plan is being discussed with a potential client (including individual and group policyholders and certificate holders). All marketing materials shall include a statement that a Colorado Health Plan Description Form for each policy being marketed or sold is available immediately upon request. The carrier shall ensure that the form is given to the potential client within three (3) business days of such a request;
 - 3. As part of the policyholder's and, if different, the certificate holder's application for coverage before an application for coverage is actually filled out;
 - 4. As part of the health plan description materials given to employees who have the option of selecting such a plan during an open enrollment period; and
 - 5. Upon request, to any person covered by a health benefit plan of the carrier.

The examiners reviewed the issue date of the Colorado Health Plan Description Forms supplied by the Company, which were in use during the examination period. The examiner reviewed a systematically selected sample of forty-nine (49) small employer applications from a population of 414. The Colorado Health Plan Description Form was not provided in nineteen (19) instances during the application process.

Colorado Health Plan Description Form - Application Forms			
Population	Sample Size	Number of Exceptions	Percentage to Sample
414	49	19	39%

It appears that the Company, in some cases, was not in compliance with the requirements of the Regulation.

Recommendation No. 2:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-2-20(IV). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that Company procedures ensure that required forms are timely implemented.

Issue B3: Failure to comply with disclosure requirements for printed marketing materials.

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., as amended effective November 1, 1997, 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 the 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 Sections 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.

- C. Small employer carriers are not required to include the disclosure information set forth in sections 9A and 9B of this regulation on the Colorado Health Benefit Plan Description Forms described in insurance regulation 4-2-20.

The examiner reviewed a systematically selected sample of twenty-five (25) articles of marketing materials and twelve (12) of the pieces examined did not contain a disclosure statement in a separate boxed section with bold type no less than twelve (12) points on the printed marketing and solicitation materials for the small group health products.

DISCLOSURE STATEMENT - MARKETING MATERIAL			
Population	Sample Size	Number of Exceptions	Percentage to Sample
545	25	12	48%

<u>Contract Form</u>	<u>Form Number</u>
CO Designed Medical Indemnity Insurance Options Brochure, 08/97	GP39320-3
CO Designed Medical PPO Insurance Options Brochure, 07/98	GP39321-3
PrinChoice Comprehensive Medical Insurance Brochure, 07/98	GP43298-2
PrinChoice Comprehensive Medical Insurance Brochure, 08/98	GP43298-3
IEA PrinChoice Indemnity PPO Insurance Brochure, 07/98	GP43299-2
IEA PrinChoice Indemnity Insurance Brochure, 08/98	GP43299-3
PrinChoice Indemnity PPO Brochure, 04/98	GP43300-1
PrinChoice Comprehensive Medical Insurance Brochure, 07/98	GP43300-2
PrinChoice Comprehensive Medical Insurance Brochure, 08/98	GP43300-3
Indemnity PPO Medical Proposal, 04/98	GP44666-CO
Indemnity PPO Medical Proposal, 08/98	GP44666-1CO
Indemnity PPO Medical Proposal, 10/98	GP44666-2CO

Recommendation No. 3:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation 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 implemented procedures to ensure that it has revised its solicitation materials to include the required disclosure statement.

COMPLAINT FINDINGS

Issue C1: Failure to record all written complaints, appeals and grievances in the Complaint Register.

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. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this paragraph (i), "complaint" shall mean any written communication primarily expressing a grievance.

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

A. First Level Appeal Review

1. A health carrier shall establish written procedures for a standard appeal of an adverse determination. The procedures shall specify whether a first level appeal request must be in writing or may be submitted orally. Pursuant to Section 10-3-1104(1)(I), C.R.S., all written requests for a standard first level appeal review must be entered into the carrier's complaint record. . . .

Regulation 6-2-1, Complaint record maintenance, promulgated pursuant to Section 10-3-1110, C.R.S., states:

V Maintenance of record

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

The Company did not maintain a complete record of all complaints, appeals and grievances in the Master Complaint Register as required by Colorado insurance law. The Company's Master Complaint Register of seventy-seven (77) complaints (inclusive of Division of Insurance Complaints) did not include two of its Level 1 Utilization Review Appeals. The two appeals were not logged with other complaints although the Company's Complaint Handling Procedures require such complaints, appeals and grievances to be so logged.

Recommendation No. 4:

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. and Regulations 4-2-17(VIII) and 6-2-1(V). In the event the Company is unable to show proof, it should provide to the Division of Insurance that it has revised its complaint handling procedures to ensure that all complaints, appeals and grievances are properly and fully recorded in the Company's Master Complaint Register.

**UNDERWRITING
POLICY FORM
FINDINGS**

Issue E1: Failure to correctly define “eligible employee.”

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

- (15) “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.

Regulation 4-6-8 (V), Concerning Small Employer Health Plans, promulgated pursuant to Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 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

- (1) The Division of Insurance finds that, when defining “eligible employee” in Section 10-16-102(15), C.R.S., the sole intent of the General Assembly was to create a maximum weekly work requirement which small employer carriers may impose as a requirement for an employee’s participation in a plan of health benefits. *Nothing in the definition of “eligible employee” was intended to limit an employer’s traditional ability to set internal standards for employee eligibility based upon the terms and conditions of employment.* . . . [Emphasis added.]
- (2) 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. . . . [Emphasis added.]

The Company’s forms, under “Part 1 – Definitions,” states:

Eligible Employee

Any employee who works for an Eligible Small Employer on a *full-time basis*...(Emphasis added.)

Colorado small employer group health insurance definition of “eligible employee” does not require an employee to be working on a “full-time basis.”

The Company’s PrinChoice Certificate states that an “eligible employee” is one “who is regularly scheduled to work for a Small Employer on a full-time basis with a normal work week of 40 or more hours. . . .” The Company’s PrinChoice Policy states that an “eligible employee” is one “who is regularly scheduled to work for a Small Employer on a full-time basis with a normal work week of 30 or more hours. . . .”

The Colorado insurance law requires the insurer to provide policies and certificates that reflect a normal work week of 24 or more hours and “full-time” is not mentioned in the definition of “eligible employee.” Only the employer may determine that the employee must work more hours per week to qualify for health insurance coverage, not the insurer.

The following forms contained language that did not correctly define "eligible employee:"

<u>Contract Type</u>	<u>Form Number</u>
Group Plan GME 45678, pages 11, 55	GH 115(SE) CO-1
PrinChoice Policy, pages 6, 16	GC5002 SE (CO)-1
PrinChoice Certificate, pages 1, 82	GH 136 A (SE)-1
Group Policy GME 85254, page 1	GC 510
Pre-PrinChoice Policy, page 11	GC 510(SE) CO-1
Pre-PrinChoice Certificate, page 38	GH 115(SE) CO-1 & GH 136 (CO)
Pre-PrinChoice Policy, pages 1, 3	GC 510(SE) CO-1

Recommendation No. 5:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. and Regulation 4-6-8(V). 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 employer group policy forms to reflect the correct definition of “eligible employee.”

Issue E2: Failure to indicate the differences between benefit levels for mental illnesses and biologically based mental illnesses in the Company's Basic and Standard Health Benefit Plans.

Section 10-16-104, C.R.S., Mandatory Coverage Provisions, Mental illness, states:

- (5)(c) An entity subject to the provisions of part 2 or 3 of this article may establish a copayment requirement for mental illness, which may or may not differ from the copayment requirement established for any other condition or illness; except that copayment requirements for mental illness shall not exceed a fifty percent copayment requirement.
- (5.5) Biologically based mental illness.
- (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.

Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, as amended January 1, 1998, promulgated pursuant to Sections 10-1-109, CRS, 10-16-105(7.2) and 10-16-108.5(8), C.R.S., states:

III. RULES

- A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's guaranteed issue program for small employers pursuant to Section 10-16-105(7.3), C.R.S. and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

IV. 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.

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

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

BASIC HEALTH BENEFIT PLAN

- 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.)

Institutional care:

Maximum 45 inpatient or 90 partial or residential days/year	50%	50%	50%
---	-----	-----	-----

Outpatient care Plan/insurer pays maximum \$1,000 per year.	50%	50%	50%
--	-----	-----	-----

STANDARD HEALTH BENEFIT PLAN

- 11. 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.)

Institutional care:

Maximum 45 inpatient or 90 partial or residential days/year	50%	50%	50%
---	-----	-----	-----

Outpatient care Plan/insurer pays maximum \$1,000 per year.	50%	50%	50%
--	-----	-----	-----

In its Basic and Standard Health Benefit Forms, in the “Mental or Nervous Disorders” Section, under “(1) Inpatient Hospital Services,” the Company stated that benefits for mental or nervous disorders “will be payable the same as for any other sickness for not more than 45 days of confinement each calendar year for each insured person.”

Under “(2) Partial Hospitalization” it stated that “Benefits will be payable the same as for any other sickness for not more than 90 days of confinement each calendar year for each insured person.”

Under “(3) Outpatient Services,” it stated that “Benefits will be payable the same as for any other sickness up to a maximum benefit of \$1,000 for each insured person each calendar year.”

1. The Company’s provisions are more generous than the mental illness benefits required by the state mandated Basic and Standard Health Benefit Plans except for biologically based mental illnesses included in the Plans’ NOTE section and as specified in Section 10-16-104(5.5), C.R.S. The Company’s Basic and Standard Health Benefit Plans are required to conform to the tables provided in Regulation 4-6-5.
2. The Company’s Basic and Standard Health Benefit Plans should also clarify coverage of biologically based mental illnesses in the schedule of benefits or add a footnote to its forms as specified in Regulation 4-6-5.

The benefits described in the following forms in the Company's Basic and Standard Health Benefit Plan suggest that the Company is not administering claims for biologically based mental illness according to Colorado insurance law:

<u>Contract Type</u>	<u>Form Number</u>
Master Basic Indemnity Plan, pages 6, 7	GH 102(SE) CO
Master Standard Indemnity Plan, pages 6, 7	GH 102(SE) CO-2
Basic and Standard Indemnity Plans, pages 20, 21	GC 552 (SE) CO-2
Basic and Standard PPO Plans, pages 25-26	GH 400 (SE) CO-1
Basic and Standard Conversion Plans, page 31	GH 402-1(MGCT)CO BASIC
	GH 402-1(MGCT)CO PPO
	GH 100 (MGCT) CO STD
	GH 100 MGCT) CO PPO
PPO Standard Health Benefit Plan, page B 3	GH 552(SE) CO-1

Recommendation No. 6:

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. 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 Health Benefit Plans to reflect the differences in benefit levels for mental illnesses and biologically-based mental illnesses.

Issue E3: Failure to provide for benefits for auto accident injuries in the absence of No-Fault Automobile Insurance.

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

III. RULES

A. Definitions

2. Plan”

- a. A “plan” is a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage which will be considered in applying the COB provision that contract. The right to include a type of coverage is limited by the rest of this subsection (III)(A)(2).

- f. “Plan” may include the medical benefits coverage in group, group-type, and individual automobile “no-fault” type contracts. *(Note: Entities subject to this regulation must comply with the COB provisions of Colorado No-Fault Regulation 5-2-3).* [Emphasis added.]

“Plan” may include Medicare or other governmental benefits. . . .

- 4. “Primary Plan” means one whose benefits for a person’s health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either (a) or (b) below is true.
 - a. The plan either has no order of benefit determination rules, or it has rules which differ from those permitted by regulation.
 - b. All plans which cover the person use the order of benefit determination rules required by this regulation and under those rules the plan determines its benefits first.

D.

4. Prohibited Coordination and Benefit Design

- a. 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.

- b. No contract may contain a provision that its benefits are “excess” or “always secondary” to any plan defined in subsection (III)(A)(2), except in accordance with the rules permitted by this regulation.

Regulation 5-2-3, Auto Accident Reparations Act (No-Fault) Rules and Regulations, promulgated under the authority of Sections 42-1-204, 10-4-704, 10-4-718, and 10-1-109, C.R.S., (III)(C)(1), Coordination of Benefits, states:

Except as provided in Section 10-4-707(5), C.R.S., regarding workers’ compensation, benefits payable under the Colorado Accident Reparations Act are “primary.” Some providers, to avoid duplication of benefits available through other insurance or contract rights, are required to coordinate their benefits as specified in Section 10-4-709, C.R.S. *Coordination of benefits shall not apply when personal injury benefits are not provided under a policy of automobile insurance.* [Emphasis added.]

The Company’s forms, “Coordination with Other Benefits” states:

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

The benefits of this policy will not be available to an insured person to the extent of minimum benefits required by the “no-fault” law for injuries suffered by the insured person which operating or riding in a motor vehicle owned by the insured person while operating or riding in a motor vehicle owned by the insured person if said vehicle is in operation on the public highways of the state of Colorado and such vehicle is not covered by no-fault automobile insurance as required by law....

Regulation 5-2-3, the regulation to which Regulation 4-6-2 refers, requires that “coordination of benefits shall not apply when personal injury benefits are not provided under a policy of automobile insurance.” In the absence of the required no-fault coverage, the health insurance carrier must pay for the insured motorists’ personal injury benefits, which the automobile insurance carrier for insured motorists normally pays.

The following forms contain language that indicates the Company's failure exclude uninsured motorists from the Company's requirement to coordinate payment of the minimum benefits as required by the Colorado State no-fault automobile insurance law:

<u>Contract Type</u>	<u>Form Number</u>
Basic Indemnity Plan, page 41	GC 552(SE) CO-2
Basic PPO Plan, page D 1	GC 596 (SE) CO
PrinChoice Policy, page 44	GH 156 (SE) CO
PrinChoice Certificate, page 67	GH 166 CO
Group Policy GME 85254, page D 2	GC 546 CO-1
Master Basic Indemnity Plan, page 42	GH 156 (SE) CO
Master Standard Indemnity Plan, page 40	GH 596 (SE) CO
PPO Standard Health Benefit Plan, D 2	GC 596(SE) CO

Basic and Standard Conversion Indemnity Plans, pg 27	GH 156-1(MGCT) CO
Basic and Standard Conversion PPO Plans, page 29	GH 156-1 (MGCT) CO
Group Plan GME 45678, page 40	GJ 156 CO-1
Pre-PrinChoice Indemnity Policy, page D 2	GC 596 CO-1
Pre-PrinChoice Certificate, page 42	GH 156 CO-1

Recommendation No. 7:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulations 4-6-2 and 5-2-3. 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 exclude the uninsured motorists from its requirement to coordinate with Colorado no-fault automobile insurance law.

Issue E4: Failure to disclose the availability of hospitalization and general anesthesia for dental procedures for dependent children.

Section 10-16-104(12), C.R.S., Hospitalization and general anesthesia for dental procedures for dependent children, 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 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.

Colorado insurance law effective required hospitalization and general anesthesia for dental procedures for dependent children September 1998.

The Company's definition of "dental services" includes:

Any confinement, treatment, or service provided to diagnose, prevent, or correct:

Periodontal disease; . . .

Malocclusion; . . . and/or

Ailments or defects of the teeth and supporting tissue and bone (excluding appliances used to close an acquired or congenital opening. However, the term Dental Services will include treatment performed to replace or restore any natural teeth in connection with the use of any such appliance.)

The Company's "Limitations" Section excludes coverage "for dental services or materials, except as described under Covered Charges."

None of the Company's certificates or amendatory endorsements discloses the availability of the mandated benefits of hospitalization and general anesthesia for dental procedures for dependent children. Without this information, the certificate holders would have no knowledge of the availability of these benefits during the period of the examination.

The following certificates and/or forms failed to address the availability of hospitalization and general anesthesia for dental procedures for dependent children:

<u>Contract Type</u>	<u>Form Number</u>
PPO Standard Health Benefit Plan, B 15	GC 552(SE) CO-1
Colorado Master Basic PPO Plan, B 15	GC 552(SE) CO-1
Colorado Master Basic Indemnity Plan, page B 15	GC 402(SE) CO-2
Colorado Master Standard Indemnity Plan, pages 27, 51	GH 136(SE) CO-1
Group Policy GME 85254, pages B3, B11	GC 510-1
PrinChoice Indemnity Policy, pages 5, 11	GC 5013 CO
	GC 5002(SE) CO-1
PrinChoice Certificate, pages 53, 80	GH 407B CO
PrinChoice Brochure, pages 4, 10, 26	GP 43298-3
Master Basic/Standard PPO Plan, page 14	GH 402 (SE) CO-1
Basic and Standard Conversion Plans, Pages 18, 20, 34, 37	GH 402-1(MGCT)CO
	GH 402-1(MGCT) CO PPO
	GH 100 (MGCT) CO
	GH 100 (MGCT) CO PPO
Pre-PrinChoice Policy, pages I2, I3	GC 552 CO-1
Pre-PrinChoice Certificate, page 51	GH 136(SE) CO-1

Group Plan Certificate 45678, pages 30, 50

GH 402 CO-1

Indemnity Standard Health Benefit Plan, page I 1, 13

GC 510(SE) CO

Recommendation No. 8:

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 its forms to disclose the availability of hospitalization and general anesthesia for dental procedures for dependent children.

Issue E5: Failure to disclose to certificate holders the state mandated benefits for diabetics.

Section 10-16-104(13), C.R.S., Diabetes, 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.
- (d) Private third-party payors shall not reduce or eliminate coverage due to the requirements of this subsection (13).

The Company's certificate forms do not contain the mandated benefits for diabetics, including equipment, supplies, and outpatient self-management training and education. The Colorado insurance law mandating these additional benefits for diabetics was effective July 1, 1998, and neither the Company's certificate forms or any of its amendatory endorsements reflected these new requirements.

The following forms did not contain language relating to the mandated diabetes coverage:

<u>Contract Type</u>	<u>Form Number</u>
Colorado Master Basic Indemnity Plan	GH 102(SE) CO
Colorado Master Standard Indemnity Plan	GH 102(SE) CO-2
Basic and Standard PPO Plans	GH 400 (SE) CO-1
Basic and Standard Conversion Plans	GH 402-1 (MGCT) CO Basic
	GH 100(MGCT) CO Standard
PrinChoice Indemnity and PPO Policy	GH 156 (SE)
PrinChoice Indemnity and PPO Certificate	GH 166CO
Group Plan Certificate 45678	GJ 156 CO-1
Pre-PrinChoice Policy	GC 596 CO-1
Pre-PrinChoice Certificate	GH 156 CO-1

Recommendation No. 9:

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. 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 include a description of the mandated coverages for diabetes.

Issue E6: Failure to provide the required benefit levels for skilled nursing care in the Company's state mandated Standard Health Benefit Indemnity and PPO Plans.

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:

III. RULES

- A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's guaranteed issue program for small employers pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

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

STANDARD PLAN TABLE

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN	
		IN	OUT
16A. SKILLED NURSING FACILITY CARE	70%	80%	50%

The Company's Standard Health Benefit Plans describe the benefit percentages that would be paid for skilled nursing care as follows:

Covered Charges for each day will not be more than 50% of:

- a. the actual room charge (if the Hospital confinement was in a semiprivate room); or
- b. the Hospital Room Maximum (if the Hospital confinement was in a private room);

Regulation 4-6-5 requires that benefits for skilled nursing care is 70% for Standard Indemnity Plans and 80% for in-network Standard PPO Plans. The Company's provisions do not appear to be in compliance with this regulation.

The following forms failed to outline the correct benefits for skilled nursing care in the Company's state mandated Standard Health Benefit Indemnity and PPO Plans:

<u>Contract Form</u>	<u>Form Number</u>
Standard Indemnity Certificate, page 12	GC 552 (SE) CO-1
Standard PPO Certificate, page B14	GC 552 (SE) CO-1
Master Standard PPO Plan, page 36	GH 402 (SE) CO-1
Master Standard Indemnity Plan, page 32	GH 402 (SE) CO-1
Standard Conversion Plans, page 19	GH 100 (MGCT) CO STD

Recommendation No. 10:

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 Standard Health Benefit Plans to reflect the skilled nursing care benefits as required by Colorado insurance law.

Issue E7: Failure to disclose that physical therapy and occupational therapy are covered benefits in the Company’s Basic and Standard Health Benefit Plans.

Regulation 4-6-5(III)(A), 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), CRS, states:

The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado’s guaranteed issue program for small employers pursuant to Section 10-16-105(7.3), CRS, and for use as conversion coverage pursuant to Section 10-16-108, CRS.

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), CRS, states:

TABLE: BASIC HEALTH BENEFIT PLAN

11. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	50%	70%	50%	\$20copay/visit
---	-----	-----	-----	-----------------

TABLE: STANDARD HEALTH BENEFIT PLAN

11. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	70%	80%	50%	\$10copay/visit
---	-----	-----	-----	-----------------

Outline of Coverage for Health Conversion Benefits, 7/97 and 12/97

Neither the Company’s “Summary of Benefits” form in its Basic and Standard Health Benefit Plans nor its “Description of Benefits” Section state that physical and occupational therapies are covered benefits. These coverages, required by Regulation 4-6-5, were not mentioned in the Plans, and therefore the certificate holders received incomplete information regarding their benefits.

The following forms did not contain language that clearly disclose physical therapy and occupational therapy are covered benefits in the Company's Basic and Standard Health Benefit Plans:

<u>Contract Type</u>	<u>Form Number</u>
Colorado Master Basic Indemnity Plan, pages 6, 26	GH 102 (SE) CO-2 GH 402 (SE) CO-2
Colorado Master Standard Indemnity Plan, pages 6, 26	GH 102 (SE) CO-2 GH 402 (SE) CO-2

Recommendation No. 11:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-5 (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 Basic and Standard Health Benefit Plans to include benefits for physical therapy and occupational therapy.

Issue E8: Failure to provide the correct number of days to commence legal action to recover benefits under the Company's Policy.

Section 10-16-214(3)(a)(XIV), C.R.S., Group sickness and accident insurance, states:

A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy.

The Company's forms state the following:

Article 7 – Legal Action

Legal action to recover benefits under this Group Policy may not be started earlier than 90 days after required proof of loss has been filed. . . .

The Company's forms are more restrictive than provided by Colorado Insurance Law that allows legal action to recover benefits to commence sixty (60) days after the proof of loss has been filed.

The following forms did not contain the correct sixty (60) day standard:

<u>Contract Type</u>	<u>Form Number</u>
PrinChoice Indemnity Policy, page C2	GC 5024-1
PrinChoice Certificate, page 74	GH 146A(MED)

Recommendation No. 12:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-214, 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 changed its policy provision for commencement of legal action to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy.

Issue E9: Failure to define preexisting condition limitations as required by Colorado insurance law.

Section 10-16-118, CRS, Limitations on preexisting condition limitations, states:

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

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

1. The Company's PrinChoice policy and certificate and Group Policy GME 85254 forms are incomplete in that they do not exclude the adopted child from the pre-existing condition limitations as required by Section 10-16-118, C.R.S.

2. The Company's PrinChoice Brochure states that the preexisting condition exclusion applies to:

Initial enrollees (employees and dependents who enroll on the firm's effective date) if your group has less than *12 months* of prior coverage. [Emphasis added.]

In its "Replacing Prior Coverage" Section, the Brochure states:

. . . . However, the Principal will not pay for any condition still subject to the prior coverage's preexisting condition exclusion if the prior coverage was in effect for less than 12 months.

If the initial enrollees accrued six months of coverage on another carrier's group plan, they would not be subject to preexisting condition exclusion requirements as implied by the Company's forms.

3. The Company's Basic and Standard Health Benefit Plans state:

Article 1 – Definition

A Preexisting Condition is a sickness or injury for which a Member or Dependent is confined or received treatment or service in the six-month period before he or she became insured under this policy.

The Company's definition of preexisting condition is incomplete because it does not follow the definition as stated in Section 10-16-118, C.R.S. Additionally, the Company's definition does not exclude-adopted children or pregnancy from the pre-existing conditions limitations as required by Colorado insurance law.

The following forms do not provide a complete definition of pre-existing condition limitations:

<u>Contract Type</u>	<u>Form Number</u>
Group Plan 45678 Certificate, page 35	GH 450(SE) CO
Group Policy GME 85254, page G2	GC 592-B
PrinChoice Indemnity Policy, E1	GC 5027A
PrinChoice Indemnity Certificate, page 61	GH 451 B
PrinChoice Brochure, pages 19, 20	GP 43298-3
Master Basic Indemnity Plan, page C 2	GC 592(SE) CO
Indemnity Standard Health Benefit Plan	GC 592(SE) CO
PPO Standard Health benefit Plan	GC 592(SE) CO
Master Standard Indemnity Plan, page 40	GH 450 (SE) CO
Master Basic/Std PPO Plan, page 36	GH 145 (SE) CO
Basic/Standard Health Plan Certificate, page C2	GC 592 (SE) CO
PPO Standard Health Benefit Plan	GC 592(SE) CO
Pre-PrinChoice Group Policy, page C 1	GC 592(SE) CO
Pre-PrinChoice Certificate, page 12	GH 115(SE) CO-1

Recommendation No. 13:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-118 (I), 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 a complete definition of pre-existing condition limitations.

Issue E10: Failure to correctly describe and apply “qualifying previous coverage” in the Company’s Basic and Standard Health Benefit Plans, as required by Colorado insurance law.

Section 10-16-104(3)(a)(I), C.R.S., Mandatory coverage provisions, Maternity coverage, states:

. . . . Policies or contracts shall not exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition.

Section 10-16-118 (1)(a)(I), C.R.S., Limitations on preexisting condition limitations, states:

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

Regulation 4-2-12(IV)(6), Concerning Pre-existing Conditions and Qualifying Previous and Existing Coverages, promulgated under the authority of Sections 10-1-109(1) and 10-16-109, C.R.S., states:

- A. In determining whether a plan of health benefits or other health benefit arrangement (whether public or private) shall be considered qualifying previous coverage or qualifying existing coverage, a carrier shall interpret Section 10-8-602(8.5) and 10-16-102(37), C.R.S., no less favorably to a covered person and dependents than the following:
- (1) A health insurance policy, certificate or other health benefit arrangement shall be considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement.
 - (2) A health insurance policy, certificate or other benefit arrangement shall be considered to provide benefits similar to or exceeding the benefits provided under the basic health benefit plan if the policy, certificate or other benefit arrangement provides benefits that:
 - (a) Provides coverage for hospitalization and physician services that is substantially similar to or exceeds the coverage for such services in the basic health benefit plan, *except that to qualify as qualifying previous or existing coverage an individual health benefit plan need not have covered either normal maternity or mental health services.* [Emphasis added.]

- (3) An individual who maintains coverage under *one or more individual health insurance policies for at least twelve (12) months (e.g., two six-month policies, three four-month policies, etc.)* that are issued under the provisions of Section 10-16-201 to 10-16-212, C.R.S., including coverage issued by a health maintenance organization or nonprofit hospital or medical service corporation plan, and that provide benefits similar to or exceeding the benefits provided under the basic or standard health benefit plan shall be deemed to have met the requirement under Sections 10-8-602(8.5)(c) and 10-16-102(37)(c), C.R.S., for qualifying existing and qualifying prior coverage, if there was a gap in coverage of no more than thirty-one (31) days between such policies. [Emphasis added.]
- (4) *All of an individual's previous coverage under any sequential combination of Medicare, Medicaid, a large group health benefit plan, a small group health benefit plan, or an individual health benefit plan, with no gap between coverages of more than ninety (90) days and no gaps between sequential individual coverages of more than 31 days,* shall be deemed to be qualifying existing or qualifying prior coverage if the plans provided benefits similar to or exceeding the benefits provided under the basic or standard health benefit plan. [Emphasis added.]
- (5) Coverage provided through the *Colorado Uninsurable Health Insurance Plan* shall qualify as qualifying previous or existing coverage. [Emphasis added.]

1. The Company's Basic and Standard Plans, "Preexisting Conditions Restrictions" Section states:

In determining whether the Preexisting Condition Restriction applies to a person, credit will be given with respect to *a particular service* for the period of time an individual was covered by Qualifying Previous Coverage if the previous coverage: [Emphasis added.]

This should be provided for any benefit with respect to the service;

The Company does not exempt pregnancy or mental health services from its application of the preexisting condition restrictions.

2. The Company's Basic and Standard Health Benefit forms, "Definitions" Section, state that "qualifying coverage" includes:

- an individual-based health insurance policy including coverage issued by an HMO or prepaid hospital or medical care plan that provides benefits similar to or exceeding benefits provided under the State's Basic or Standard Health Benefit Plan, provided that such policy has been in effect for a period of at least one year; except that such individual policy need not cover maternity or mental health care.

Although the Company's definition in this portion of the form does include that the individual policy need not cover maternity or mental health care (missing in the requirements for preexisting condition exemption), it does not speak to the "sequential combination" of health plans that would also meet the requirements for qualifying previous coverage.

3. The Company's Basic and Standard Health Benefit form, "Definitions" Section, does not include the Colorado Uninsurable Health Insurance Plan as qualifying coverage.

The following forms do not correctly describe and apply "qualifying previous coverage" in the Basic and Standard Health Benefit Plans:

<u>Contract Type</u>	<u>Form Number</u>
Master Standard Indemnity Policy, pages 40, 59-60	GH 136 (SE) CO
Master Standard PPO Policy, pages 40, 59-60	GH 136 (SE) CO
Master Basic Indemnity Certificate, page 37	GC 592 (SE) CO
Master Basic PPO Policy, page C 1	GC 592 (SE) CO
Indemnity Standard Health Benefit Plan, page 9	GC 510(SE) CO
PPO Standard Health Benefit Plan, page I 9	GC 510(SE) CO

Recommendation No. 14:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-104(3) and 10-16-118(1), C.R.S. and Regulation 4-2-12(IV). 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 so that its certificate holders' previous qualifying coverage is correctly calculated.

Issue E11: Failure to include complete benefits for transplants in the Company's Basic and Standard Health Benefit 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., states:

III. RULES

- A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's guaranteed issue program for small employers pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

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

BASIC HEALTH BENEFIT PLAN

Footnote ¹⁸: 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 bone marrow transplants. Transplants will be covered only if they are medically necessary and the facility meet clinical standards for the procedure.

STANDARD HEALTH BENEFIT PLAN

Footnote ¹⁰: 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 bone marrow transplants. Transplants will be covered only if they are medically necessary and the facility meet clinical standards for the procedure.

The Company's Basic and Standard Health Benefit Plans, Article 3, "Covered Benefits" Section state the following transplants are covered:

- r. the following human-to-human organ or tissue transplants (including charges for organ or tissue procurement) that meet the clinical requirements of the facility where the transplant is performed:
- (1) heart; and
 - (2) liver; and
 - (3) kidney; and
 - (4) cornea; and
 - (5) bone marrow for aplastic anemia, leukemia, immunodeficiency disease, and Wiskott-Aldrich

syndrome;

The Company's coverage's are incomplete because they do not include heart/lung or bone marrow for neuroblastoma, lymphoma, or high-risk stage II and stage III breast cancer.

The following forms do not reflect the complete benefits for transplants in the Basis and Standard Health Benefit Plans:

<u>Contract Type</u>	<u>Form Number</u>
Basic Indemnity Health Benefit Plan, page B8	GC 552 (SE) CO-1
Standard Indemnity Health Benefit Plan, page B8	GC 552 (SE) CO-1
Master Standard Indemnity Policy, page 28	GH 402 (SE) CO-1
Master Standard PPO Plan, pages 30-31	GH 402 (SE) CO-1
Master Basic Indemnity Plan	
Master Basic PPO Plan	
Basic Conversion Plan, page 16	GH 402-1 (MGCT)CO BASIC
Standard Conversion Plan, page 16	GH 100 (MGCT) CO STD

Recommendation No. 15:

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 forms to include a complete list of transplant coverages in its Basic and Standard Health Benefit Plans.

Issue E12: Failure to comply with Colorado Insurance Law by requiring “proof of good health” for new entrants and late enrollees.

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 the 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 [emphasis added]:

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

- (24) “Health status” means the determination by a carrier of the past, present, or expected risk of an individual or the employer due to the health conditions of the employees of the employer.
- (24.5) “Health status-related factor” means any of the following factors: Health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; *evidence of insurability* including conditions arising out of acts of domestic violence; and disability. (Emphasis added)
- (26) “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
 - (a) The individual:
 - (I) Was covered under other creditable coverage at the time of the initial enrollment period, and, if required by the carrier or issuer, the employee stated at the time of initial enrollment that this was the reason for declining enrollment;
 - (II) Lost coverage under the other creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or employer contributions towards such coverage was terminated; and
 - (III) Requests enrollment within thirty days after termination of the other creditable coverage; or

- (b) The individual is employed by an employer that offers multiple health benefit plans and elects a different plan during an open enrollment period;
- (c) A court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan and the request for enrollment is made within thirty days after issuance of such court order; or
- (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 if a request for enrollment is received in a timely fashion before such date.

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

(7.3)(c)(II) Effective January 1, 1995, a small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for such health benefit plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with this article. Effective July 1, 1997, a small employer carrier shall also issue any of its other small employer plans to any small employer that applies for such a plan; except that this requirement shall not apply to a business group of one where the business group of one does not meet the carrier's normal and actuarially-based underwriting criteria. . . . [Emphasis added.]

(7.3)(c)(II) A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if:

(B) The criteria are not related to the health status or claim experience of the small employer;

Section 10-16-214(4), group Sickness and Accident Insurance, effective July 1, 1997, states"

A carrier offering a group health benefit plan shall not establish rules for eligibility for any individual to enroll under the plan based on any health status-related factors in relation to the individual or a dependent of the individual.

Regulation 4-6-5(III), 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), CRS, states:

B. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's guaranteed issue program for small employers pursuant to Section 10-16-105(7.3), CRS, and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

Regulation 4-6-7(5), Concerning Premium Rate Setting for Small Group Health Plans, 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:

- D. Rate Adjustment Factor for Small Group Plans Issued or Renewed On or After January 1, 1998. The rate adjustment factor for small group plans issued or renewed on or after January 1, 1991, shall be 1.0. This means the case characteristic-adjusted index rate calculated pursuant to subsection A of this regulation *may not be further adjusted using any other factors*. . . .
(Emphasis added)

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), 10-16-105 (5), 10-16-105 (7.3), 10-16-108.5(8), and 10-16-214 (1) (d), C.R.S., states:

C. Covering New Entrants

- (4) New entrants to a group shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude coverage for preexisting medical conditions or impose a carrier waiting period, consistent with the provisions of Section 10-16-118, C.R.S.
- (5) If a policy provides for an annual open enrollment period during which all employees and dependents are eligible for coverage, then a carrier shall issue coverage to late entrants at the time of open enrollment on the same terms and conditions as other enrollees, even if they have not fulfilled the late entrant exclusion periods otherwise mandated by Section 10-16-118(1)(c), C.R.S.

As of July 1997, Colorado insurance law prohibited the small employer group carriers to use health status as a factor in determining the acceptance of a small employer group, except as it relates to a business group of one. Section 10-16-214, C.R.S., does not allow health status related - related factors of the applicant or dependent to be a basis for the Company's acceptance of the individual.

The Company certificate forms, in the "Eligibility and Effective Dates," Section, contains the following statements for employee coverage provisions and dependent coverage provisions:

1. The Company's PrinChoice Comprehensive Medical Insurance Brochure, in the "Employee Enrollments" section states, "Employees need to complete an enrollment form provided by the Principal. In addition, they may need to provide a health statement. If a health statement is required, it will be used for group premium, case management or reinsurance purposes. Eligibility for coverage will not be based on health status."
2. The Company's form GH 115 A (MED), under "Statement of Health Requirements" states, "A statement of health, in a form provided by The Principal, may be required from you when you first request insurance under the Group Policy. The statement of health will be used for case management or reinsurance purposes. In no event will a person be declined

for insurance, or charged and additional premium, due to his or her health status."

EMPLOYEE EFFECTIVE DATE

If request for contributory coverage is made by a *Late Entrant* as defined below, coverage will be in force on the date *We approve such proof of good health as may be required by Us*. However, if *We do not approve such proof of good health*, coverage will be in force on the date 12 months after the date of the request, . . .[Emphasis added.]

The type and form of required proof of your good health will be determined by Us. . . .

If you are a Timely Entrant as defined below, *you must submit proof of good health when you initially request coverage under this plan*, . . .[Emphasis added.]

DEPENDENT EFFECTIVE DATE

If a Member is eligible for Dependent Medical Expense Insurance, such insurance will become effective under the same terms as set for the for Member Medical Expense Insurance in this Section B, Article 1, except as described below.

- a Any *required statement of health* will be with respect to the health of the Member's Dependents.

If you are a *Late Entrant as defined below*, *you must submit proof of good health when you request coverage*. . . .If a *Late Entrant's proof of good health is not approved by Us*, that person's coverage will be deferred for 12 months. . . .[Emphasis added.]

If you are a Late Entrant as defined below, *you must submit proof of good health* when you request coverage. . . . *Proof of good health must again be submitted when requesting coverage* at the end of the 12 month deferral period. [Emphasis added.]

The type and form of required proof of good health will be determined by the Company. A *Member must submit proof as described below*: [Emphasis added.]

- 1) If a Member is a Timely Entrant as defined in d. below, the *Member must submit proof of good health when he or she is first eligible* . . . [Emphasis added.]
- 2) If a Member is a Late Entrant as defined in d. below, *the Member must submit proof of good health when he or she initially requests insurance under this policy*. . . .If a *Late Entrant's proof of good health is not approved by the Company*, that person's insurance will be deferred for 12 months. . . . [Emphasis added.]

If a request for contributory insurance is made by a Late Entrant as defined in d. below, insurance will be in force on the date the Company approves such *proof of good health*. . . . However, if *the Company does not approve such proof of good health insurance will be in force on the date 12 months after the date of the request provided on such date*: [Emphasis added.]

The Company's certificate forms do not comply with Colorado insurance law in that the Company contracts:

1. Delay eligibility of some potential enrollees under the plan based on health status related factors.
2. May request the employee to provide a health statement to be used for group premium

Colorado insurance law does not permit:

1. eligibility to be based on the health status of employees or dependents.
2. the Company to require an enrollee to provide a health statement to be a factor for premium rate settings. The case characteristic-adjusted index rate calculated pursuant to subsection A of this regulation *may not be further adjusted using any other factors*. . . . (Emphasis added)

The following forms contain language that suggest the Company requires "proof of good health" for new entrants and late enrollees:

<u>Contract</u>	<u>Form Number</u>
PrinChoice Comprehensive Medical Insurance Brochure, 08/98	GP 43298-3
Group Plan GME 45678	GH 115 A (MED) GH 115 (SE) CO-1 GC 5007 CO-1
Group Plan GME 12345	GH 115 (SE) CO
Group Plan GME 12345A	GH 115 (SE) CO-1
Master Standard PPO	GH 115 (SE) CO GC 530 GC530-2 GC 530 (SE) CO

Recommendation No. 16:

Within 30 Days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104(1), 10-16-102, 10-16-105(7.3), 10-16-214(4) and Regulations 4-6-5(III), 4-6-7(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 these forms to remove any reference to health status a condition of eligibility. The Company should work with the Division of Insurance to ensure that no eligible person was denied coverage or had limited coverage because of contract wording.

Issue E13: Failure to include the correct disclosure statement on Small Employer 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., which was *in effect on November 1, 1997*, 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, 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 Company forms listed below contain disclosure wording different from that required by Regulation. The Forms state:

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE 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.

The following Company forms contained the above disclosure wording:

<u>Contract Type</u>	<u>Form Number</u>
Application for Group Insurance for Small Employer Groups	GP39153-1, CO 8/95
Colorado Application for Group Insurance	GP41990 CO 2/97

Recommendation No. 17

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-5(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 the marketing materials to include the required disclosure statement.

UNDERWRITING - RATES

Issue F1: Failure to identify unique index rate upon which the Company's small group rates were based.

Section 10-16-105(8)(a)(I), C.R.S., Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans, states, in part:

The premium rate charged during a rating period to small employers shall be based on a single, same index rate, applicable to all small employers, adjusted for case characteristics and coverage; . . .

The Company did not specifically identify the unique Index Rate in any of the rate filings reviewed for the examination period for small group rates. This requirement is mandated by statute. The Division of Insurance wrote letters to the Company during 1998 and 1999 outlining this problem. It appears the Company has revised its procedures to ensure rate filings are made in accordance with Colorado insurance law.

Recommendation No. 18

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105(8). during the examination period. 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 rate filings are made in accordance with Colorado insurance law.

Issue F2: Failure to initially provide adequate rating data to support the underlying rating assumptions used to develop rates and to include a certified actuarial memorandum certified by a qualified actuary that described the basis used to determine the rates.

Regulation 4-2-11(III), Individual and Group Health Insurance Rate Filings, Rate Filing Requirements, promulgated under the authority of Section 10-1-109, 10-16-107 and 10-16-109, C.R.S., Rules, provides, in part, that:

B. Rate Filing Requirements

7. Each rate filing shall include an actuarial memorandum certified by a qualified actuary, describing the basis used to determine the rates. The actuarial memorandum shall indicate and explain the calculation of the anticipated loss ratio and attest that, in the actuary's opinion, the rates are not excessive, inadequate or unfairly discriminatory.
8. Each rate filing must be accompanied by supporting rating data, including, at a minimum, credible past and prospective loss experience. Additional specific rating data, supplementary rating information or supporting information, when necessary to determine the validity of a filing, may be requested by the Commissioner.

The rate filings reviewed for the rates that were to be effective during the examination period did not provide adequate support for the underlying rating assumptions for the small group rates in effect at that time. Communication between the Division of Insurance and the Company concerning this issue resulted in subsequent filings providing more detailed support.

Recommendation No. 19

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-2-11(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 procedures to ensure that rate filings are made according to Colorado insurance law.

Issue F3: Failure to use Age Band categories with acceptable rating variables and allowable factor sets.

Regulation 4-6-7(5)(A)(3), Concerning Premium Rate Setting for Small Group Health Plans, 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., provides:

For all small employer policies issued or renewed on or after January 1, 1995, carriers using case characteristics to calculate their index rates shall use the categories listed below:

- (a) Age (12 allowable categories) This part (a) defines the acceptable age band categories, and allowable factor set.

The Company used an unnecessarily complicated version of the age band factors requirement in its small group rating methodology, for rates in effect during the examination period, which incorporated unacceptable rating variables. The methodology incorporated factors entitled "Unisex" and "Product" which are not in compliance with Regulation 4-6-7.

The Company has been working with the Division of Insurance to eliminate these unnecessary factors.

Recommendation No. 20

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-7(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 procedures to ensure that rate filings are made according to Colorado insurance law.

Issue F4: Failure to use correct geographic factor to calculate index rate for rate filing.

Regulation 4-6-7(5)(A)(3), Concerning Premium Rate Settings for Small Group Health Plans, 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:

For all small employer policies issued or renewed on or after January 1, 1995, carriers using case characteristics to calculate their index rates shall use the categories listed below:

- (b) Geographic Location - If a carrier uses geographic location to set rates then it shall use the 9 mandatory categories listed below.

The Company incorrectly used a geographic location in a rate filing, dated August 7, 1998. The filing contained an incorrect geographic factor for a Colorado county. This Colorado county falls into the <20,000 category and should have had a geographic factor of .80 to be consistent with other such counties listed in the filing. The filing listed the county factor to be .79.

The Company subsequently corrected this error following notification from the Colorado Division of Insurance.

Recommendation No. 21:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-7(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 procedures to ensure that Rate filings are made in accordance with Colorado insurance law.

Issue F5: Failure to use rating variables which were consistent with small group rating methodology.

Section 10-16-105(8)(a)(I), Small group sickness and accident insurance - guaranteed issue -mandated provisions for basic and standard health benefit plans, states, in part:

"The premium rate charged during a rating period to small employers shall be based on a single, same index rate, applicable to all small employers, adjusted for case characteristics and coverage; . . ."

Regulation 4-6-7, Section 5(A)(3), - Concerning Premium Rate Setting for Small Group Health Plans, promulgated under the authority of Section 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., specifies the acceptable case characteristics. These include age, geographic location and family size. This section of the regulation is also quite specific as to the acceptable case characteristic rating factors.

The calculation of the small group rates, described in the rate filings reviewed for the examination period, included the following variables, which were inconsistent with the acceptable small group rating methodology described in Colorado statute and regulation. The inconsistent variables included: 1) Monthly Adjustment Factor (MAF) and (2) Case Age Factor. The Company and the Colorado Division of Insurance have been working to eliminate misunderstanding and/or confusion that may exist in the presentation of the Company's age bands and factors.

The Company has removed Attachment 2, Example Age Factor Calculation, from subsequent rate filings.

Recommendation No. 22:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105(8) and Regulation 4-6-7(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 procedures to ensure that rate filings are made in accordance with Colorado insurance law.

Issue F6: Failure to offer both composite and age-banded rates as a choice to all eligible small groups and to clearly define the use of composite rating in their rating methodology filings.

Regulation 4-6-7 (6)(A), Use of Composite rates, promulgated under the authority of Sections 10-1-109(1), 10-16-105(7.2), 10-16-109, CRS, states:

Small employer carriers may offer small employers 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:

(1) The small employer carrier makes the same offer across its entire book of Colorado small group business where an employer has ten (10) or more eligible employees. The offer shall be a choice between composite rates or four-tier family, age-banded rates calculated pursuant to Section 5 of this regulation.

The rate filings reviewed for the examination period contained examples of the Company's rating methodology and contained a "Case Age Factor". It appears that this factor is equivalent to calculating a composite rate for each of the four tiers. This resulted in the Company composite rating all small groups.

Recommendation No. 23:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-7(6)(A). 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 composite rating methodology to ensure that rate filings are made in accordance with Colorado insurance law.

UNDERWRITING

CANCELLATIONS / DECLINATIONS / NON-RENEWALS

Issue H1: Failure to offer the Basic or Standard Health Benefit Plan to employees of terminated small employer policies.

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* [emphasis added] 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.
- (b) If the group's original plan had benefits which were significantly less generous in most respects than the standard plan as determined by the commissioner, the carrier is only required to offer the basic health benefit plan to such group or individual. 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 paragraph (a) of this subsection (4) and this paragraph (b) shall not apply to such an individual.
- (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.

From a population of 557 terminated small employer group policies for 1998, fifty (50) employer termination files were selected and reviewed. Five (5) policies that were terminated had employees that were not offered the Basic or Standard Health Benefit Plan by the Company when the employer's policy was terminated.

OFFERS OF BASIC AND STANDARD PLANS NOT MADE - TERMINATION FILES			
Population	Sample Size	Number of Exceptions	Percentage to Sample
557	50	5	10%

Recommendation No. 24:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 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 developed procedures to ensure that terminated employees are offered the choice of a Basic or Standard Plan upon termination of the group contract or coverage under the group contract.

Issue H2: Failure to provide a complete list of declined applications and action taken after declination.

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

A. DEFINITIONS

1. "Application" shall include any application form or enrollment form for coverage under any policy.
2. "Related Entity" shall include any person authorized to act on behalf of the insurer/carrier in connection with the business of insurance.

B. RECORDS REQUIRED FOR MARKET CONDUCT PURPOSES

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 calendar year plus two calendar years.
2. A policy record shall be maintained for each policy issued in this state. Policy records shall be maintained for the current policy term, plus two calendar years, unless otherwise contractually required to be retained for a longer period. Provided, however, documents from policy records no longer required to be maintained under this regulation, which are used to rate or underwrite a current policy, must be maintained in the current policy records. Policy records shall be maintained so as to show clearly the policy term, basis for rating and, if terminated, return premium amounts, if any. Policy records need not be segregated from the policy records of other states so long as they are readily available to the commissioner as required under this rule. A separate copy need not be maintained in the individual policy records, provided that any data relating to that policy can be retrieved. Policy records shall include:
 - a. The application for each policy, if any;
 - b. Declaration pages, endorsements, riders, termination notices, guidelines or manuals associated with or used for the rating or underwriting of the policy. Binder(s) shall be retained if a policy was not issued; and
 - c. Other information necessary for reconstruction of the rating and underwriting of the policy.

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

1. If a small employer carrier denies coverage to a business group of one for any of its health benefit plans on the basis of risk characteristic, the denial shall be in writing and shall state with specificity the reasons for the denial (subject to any restrictions related to the confidentiality of medical information). The written denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the small employer carrier. The explanation shall include at least the following:
 - a. A general description of benefits contained in each such plan;
 - b. A price quote for each such plan; and
 - c. Information describing how the business group of one can enroll in such plans.

The explanation shall be provided within the time frames provided in Paragraph G (1) directly to the business group of one or through an authorized producer.

The Company could not supply a complete list of health benefit plan underwriting files that were declined during the examination period. The Company supplied the examiner with some typical files and the action taken. A complete list, from which a random sample could be selected, was not provided. The examiner could not determine the reason for denial and there was no evidence that the denials were in writing, stating with specificity the reason for denial or if the denied employer was given a written explanation of the availability of the Basic and Standard Health Benefit Plans as is required by Colorado insurance law. No files were available to make the selection and therefore the information could not be ascertained.

Recommendation No. 25

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 1-1-7(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 procedures to ensure that records are maintained for the period required by law.

CLAIMS

Issue J1: Failure of the Company to input and track the received date of a claim that is sent to a repricer.

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

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

Regulation 4-2-7(V)(A), Concerning the payment of monetary penalties, General Provisions, states:

If claims for benefits are processed by a third party administrator or other entity acting on behalf of the insurer, the failure of such third party administrator or other entity to comply with the requirements of this regulation shall be considered to be failure of the insurer.

The Company has no procedures for inputting and tracking a “claims received date” when it is sent to a repricer. As a result of this oversight, no controls are in place to follow-up on repriced claims that the Company receives directly and then sends to the repricer for repricing. Additionally, it does not require its repricers to date the claim upon receipt.

Recommendation No. 26:

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. and Regulation 4-2-7(V). In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance of the steps taken to capture and follow-up on claim data from the repricer in order to comply with Colorado insurance law.

Issue J2: Failure, in some cases, to pay claims within the required sixty (60) days after receipt of a valid and complete claim and to properly investigate claims.

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

1. The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
 - (f)(II) 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;
 - (h)(V) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

Section 10-3-1110, C.R.S., Regulations states:

2. The commissioner may, after notice and hearing, as provided in Article 4 of title 24, C.R.S., promulgate rules and regulations with respect to the payment of benefits under group and individual contracts of accident and sickness coverage and under group and individual contracts for property or casualty coverage, except for property and casualty coverage provided pursuant to the "Colorado Auto Accident Reparations Act" part 7 of article 4 of this title, issued by organizations authorized to do business in this state under the provisions of articles 4 and 8 and parts 1, 3, and 4 of article 16 of this title. Such rates and regulations may establish a penalty payable to the claimant on benefit payments which are delayed more than sixty days after a valid and complete filing of the claim unless there is a reasonable dispute between the parties concerning such claim. Such penalty shall not exceed twenty dollars on claims of less than one hundred dollars or interest at a rate of eight percent annually on claims above one hundred dollars. In addition to such penalties payable to the claimant, the commissioner, after notice and hearing, may assess a civil penalty against any insurer of one hundred dollars per day for each day benefit payments are delayed more than sixty days after a valid and complete filing of the claim unless there is a reasonable dispute between the parties concerning such claim.

Regulation 4-2-7, Concerning the 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, promulgated under the authority of Sections 10-1-108(8), 10-1-109 and 10-3-1111, C.R.S., states in part:

(II) PURPOSE AND SCOPE

Under 10-3-1104(1)(h), C.R.S., all persons as defined in 10-3-1102(3) C.R.S. are obligated to promptly pay claims under insurance policies. 10-3-1110(2) C.R.S. authorizes the commissioner to promulgate rules and regulations with respect to the payment of benefits under group and individual contracts of sickness and accident coverage and to first party claims under individual contracts for property or casualty coverage, except for property and casualty coverage provided pursuant to the "Colorado Auto Accident Reparations Act," issued by organizations authorized to do business in this state under the provisions of Articles 4, 8, 16 and 17 of title 10, C.R.S. That section further provides that the Commissioner may impose against such organizations which fail to pay claims within 60 days, monetary penalties payable to the insured of up to \$20.00 in case of a claim of less than \$100.00 and 8 percent interest per annum in claims over \$100.00. The purpose of this regulation is to describe the procedure and the circumstances under which such penalties will be imposed.

(III) DEFINITIONS

As used in this rule, unless the context otherwise requires:

- (1) "Insurer" means those organizations which are authorized to do business in this state under the provisions of Articles 4, 8, 16 and 17 of Title 10, C.R.S.

(IV) PENALTY

(A) Whenever it is brought to the attention of the Division of Insurance whether by written complaint, investigation, examination or other means, that any insurer has failed to pay a claim under any sickness and accident and property and casualty insurance policy within 60 days after the date a valid and complete claim has been received by the insurer, and unless there is a reasonable dispute between the insured and the insurer concerning the claim, the Commissioner may impose a monetary penalty to be paid by the insurer to the insured. Such penalty shall be no more than \$20.00 in the case of claims of \$100.00 or less. In the case of claims of \$100.00 or more, the amount of such penalty shall be 8 percent annual interest on the amount of the claim, from the date a valid and complete claim has been received by the insurer until the date the claim is paid by the insurer. . . .

(V) GENERAL PROVISIONS

(C) In order to comply with this regulation, the insurer must mail or otherwise deliver the benefit check to the insured or the provider, within the 60 day time period. If a benefit check is issued but not mailed or delivered within the 60 day time period, the insurer will be deemed to be in violation of this regulation. All claims must be paid promptly. The fact that a claim is paid within 60 days does not necessarily establish that the claim has been paid promptly or within a reasonable time as required by 10-3-1104(1)(h)(V) and (VI), C.R.S.

The population consisted of all claims processed during the period under examination. Systematically selected samples of one hundred (100) paid claims and one hundred (100) denied claims were reviewed. The exceptions represent the following situations in which coverage was not affirmed or denied within sixty (60) days as required by Colorado insurance law.

1. In two (2) of the five Processed Paid Claims exceptions, the lack of proper and thorough investigation of the claim file resulted in a delay in the prompt handling of claim files.
2. Two (2) of the five Processed Paid Claim exceptions were due to Company examiner errors while processing the claim. This resulted in the lack of the timely and accurate handling of claims.
3. One (1) of the five Processed Paid Claims exceptions resulted from the Company's lack of monitoring a claim that required additional follow-up after the initial receipt of the claim.

PROCESSED <i>PAID</i> CLAIMS			
Population	Sample Size	Number of Exceptions	Percentage to Sample
82,761	100	5	5%

1. In three of the seven Processed Denied Claims exceptions, the lack of proper and thorough investigation of the claim file resulted in the delay in the prompt handling of the claim files.
2. One of the seven Processed Denied Claims exceptions was due to the Company's failure to thoroughly review the claim file. This resulted in the delay in the timely and accurate handling of the claim.
3. Three of the seven Processed Denied Claims exceptions resulted from the Company's lack of monitoring procedures of claims requiring follow-up.

PROCESSED <i>DENIED</i> CLAIMS			
Population	Sample Size	Number of Exceptions	Percentage to Sample
82,761	100	7	7%

Recommendation No. 27:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104(1), 10-3-1110(2) C.R.S. and Regulation 4-2-7(V). In the event the Company is unable to show such proof, it should provide evidence to assure the Division of Insurance that it has taken immediate steps to conduct reasonable investigations and pay claims in a prompt, fair and equitable manner.

Issue J3: Failure, in some cases, to process claims accurately.

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 if such contract, or in any other manner whatever [Emphasis 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:

- (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of loss statements have been completed; or . . .

Regulation 4-2-7, Concerning the 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, promulgated under the authority of Sections 10-1-108(8), 10-1-109 and 10-3-1111, C.R.S., states in part:

(VII) PURPOSE AND SCOPE

Under 10-3-1104(1)(h), C.R.S., all persons as defined in 10-3-1102(3) C.R.S. are obligated to promptly pay claims under insurance policies. 10-3-1110(2) C.R.S. authorizes the commissioner to promulgate rules and regulations with respect to the payment of benefits under group and individual contracts of sickness and accident coverage and to first party claims under individual contracts for property or casualty coverage, except for property and casualty coverage provided pursuant to the "Colorado Auto Accident Reparations Act," issued by organizations authorized to do business in this state under the provisions of Articles 4, 8, 16 and 17 of title 10, C.R.S. That section further provides that the Commissioner may impose against such organizations which fail to pay claims within 60 days, monetary penalties payable to the insured of up to \$20.00 in case of a claim of less than \$100.00 and 8 percent interest per annum in claims over \$100.00. The purpose of this regulation is to describe the procedure and the circumstances under which such penalties will be imposed.

(VIII) DEFINITIONS

As used in this rule, unless the context otherwise requires:

- (2) "Insurer" means those organizations which are authorized to do business in this state under the provisions of Articles 4, 8, 16 and 17 of Title 10, C.R.S.

(IX) PENALTY

- (B) Whenever it is brought to the attention of the Division of Insurance whether by written complaint, investigation, examination or other means, that any insurer has failed to pay a claim under any sickness and accident and property and casualty insurance policy within 60 days after the date a valid and complete claim has been received by the insurer, and unless there is a reasonable dispute between the insured and the insurer concerning the claim, the Commissioner may impose a monetary penalty to be paid by the insurer to the insured. Such penalty shall be no more than \$20.00 in the case of claims of \$100.00 or less. In the case of claims of \$100.00 or more, the amount of such penalty shall be 8 percent annual interest on the amount of the claim, from the date a valid and complete claim has been received by the insurer until the date the claim is paid by the insurer. . . .

(X) GENERAL PROVISIONS

- (D) In order to comply with this regulation, the insurer must mail or otherwise deliver the benefit check to the insured or the provider, within the 60 day time period. If a benefit check is issued but not mailed or delivered within the 60 day time period, the insurer will be deemed to be in violation of this regulation. All claims must be paid promptly. The fact that a claim is paid within 60 days does not necessarily establish that the claim has been paid promptly or within a reasonable time as required by 10-3-1104(1)(h)(V) and (VI), C.R.S.

The following claims contained errors that resulted in underpayments, overpayments or which could affect 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 Company's subscribers.

1. Nine (9) of the 100 Processed Paid Claims exceptions resulted in the contracted providers either not being paid, or paid incorrectly.
2. Six (6) of the 100 Processed Paid Claims exceptions were due to an inadequate review of related claims when follow-up information affecting the claim files was received.

PROCESSED <i>PAID</i> CLAIMS			
Population	Sample Size	Number of Exceptions	Percentage to Sample
82,761	100	9	9%

1. Eight (8) of the 100 Processed Denied Claim exceptions were not processed accurately and resulted in the contracted providers either not being paid, or paid incorrectly.
2. Four (4) of the 100 Processed Denied Claims exceptions were due to an inadequate review of related claims when follow-up information affecting the claim file was received.
3. Ten (10) of the Processed Denied Claims exceptions were related to the Company's overall claim quality control procedures being inadequate in preventing claim processing delays and errors.

PROCESSED <i>DENIED</i> CLAIMS			
Population	Sample Size	Number of Exceptions	Percentage to Sample
82,761	100	22	22%

Recommendation No. 28:

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. and Regulation 4-2-7(V). In the event the Company is unable to show such proof, it should provide evidence to assure the Division of Insurance that it has taken immediate steps to conduct reasonable investigations and pay claims in a prompt, fair and equitable manner.

SUMMARY OF ISSUES AND RECOMENDATIONS	Rec. No.	Page No.
MARKETING AND SALES - FINDINGS		
Failure to include the correct disclosure statement on small employer marketing material.	1	16
Failure to timely implement use of the Colorado Comprehensive Health Benefit Plan Description Form.	2	18
Failure to comply with disclosure requirements for printed marketing materials.	3	20
COMPLAINTS - FINDINGS		
Failure to record all written complaints, appeals and grievances in the complaint register.	4	23
UNDERWRITING - CONTRACT FORMS - FINDINGS		
Failure to correctly define eligible employee.	5	26
Failure to indicate the differences between benefit levels for mental illness and biologically based mental illness in the Basic and Standard Health Benefit Plans.	6	29
Failure to provide for benefits for auto accident injuries in the absence of No-Fault Automobile Insurance.	7	32
Failure to disclose the availability of hospitalization and general anesthesia for dental procedures for dependent children.	8	35
Failure to disclose to certificate holders the state mandated benefits for diabetes.	9	37
Failure to provide the required benefit levels for skilled nursing care in the Company's state mandated Standard Health Benefit Indemnity and PPO Plan.	10	39
Failure to disclose that physical therapy and occupational therapy are covered benefits in the Company's Basic and Standard Health Benefit Plans.	11	41
Failure to provide the correct number of days to commence legal action to recover benefits under the Company's policy.	12	42
Failure to define preexisting condition limitations as required by Colorado insurance law.	13	44
Failure to correctly describe and apply "qualifying previous coverage" in the Company's Basic and Standard Health Benefit Plans.	14	47
Failure to include complete benefits for transplants in the Company's Basic and Standard Health Benefit Plans.	15	49
Failure to comply with Colorado Insurance Law by requiring "proof of good health" for new entrants and late enrollees.	16	54
Failure to include the correct disclosure statement on Small Employer application forms.	17	56

UNDERWRITING – RATING - FINDINGS		
Failure to identify unique index rate upon which the Company’s small group rates were based.	18	58
Failure to initially provide adequate rating data to support the underlying rating assumptions used to develop rates and include a certified actuarial memorandum certified by a qualified actuary that described the basis used to determine rates.	19	59
Failure to use Age Band categories with acceptable rating variables and allowable factor sets.	20	60
Failure to use correct geographic factor to calculate index rate for rate filing.	21	61
Failure to use rating variables which were consistent with small group rating methodology.	22	62
Failure to offer both composite and age-banded rates as a choice to all eligible small groups and to clearly define the use of composite rating in their rating methodology filings.	23	63
UNDERWRITING - CANCELLATIONS/DECLINATIONS – FINDINGS		
Failure to offer the Basic or Standard Health Benefit plan to employees of terminated small employer policies.	24	66
Failure to provide a complete list of declined applications and action taken after declination.	25	68
CLAIMS - FINDINGS		
Failure to input and track received date of a claim that is sent to a repricer.	26	70
Failure to consistently pay claims within the required sixty (60) days after receipt of a valid and complete claim and to properly investigate claims.	27	74
Failure, in some cases, to process claims accurately and promptly.	28	77

Independent Market Conduct Examiners

Donald R. Koelker, CIE, FLMI, ALHC, AIRC

Sue Howe, CIE

Lynn Zukus

Contracting with

The Colorado Division of Insurance

1560 Broadway, Suite 850

Denver, Colorado 80202

(303) 894-7499

Participated in this examination and in the preparation of this report.