Responsibilities of the Division of Insurance
In Regard to Health Insurance

(Note: The following is a general listing of the various responsibilities of the Division of Insurance in regard to major medical health insurance coverage. It does not include distinctions among certain types of insurance, such as Preferred Provider Organizations (PPOs) vs. Health Maintenance Organizations (HMOs), Medicare Supplement insurance, long term care insurance, limited insurance policies, or medical benefits under auto, liability, worker's compensation, disability income, specific disease, hospital confinement, or limited benefit health insurance.)

1. Ensure that companies entering the Colorado market have sufficient resources and organization to assure policyholders that they can fulfill the coverage promises the company makes.
    a. Review and evaluate applications for a Certificate of Authority to operate in Colorado.
    b. Annually, and regularly, review financial condition of companies authorized to do business in Colorado to assess whether have continuing financial ability to operate under the laws of Colorado.
    c. Collect premium taxes from companies subject to such.
    d. Require companies to participate in such guaranty funds as are authorized by law.
2. Perform regular financial examination of companies to ensure their continued solvency.
    a. Review quarterly financial filings to identify trends and potential problems.
    b. Require use of statutory accounting principles in presentation of financial information.
    c. Oversee solvency of companies, including asset, reserve, surplus and investment valuations.
    d. Review and approve or disapprove mergers and consolidations.
    e. Act as liquidator, conservator, or receiver when delinquencies are determined, including rehabilitation and liquidation.
    f. Conduct regular financial examinations/audits of companies to ensure correctness of information filed with the Division.
    g. Oversee insurance holding systems, including insurance company subsidiaries of other organizations and subsidiaries of insurance companies.
3. License insurance producers (agents and brokers). This includes verification of their knowledge of the laws, products and practices through pre-licensure education, examination, and continuing education requirements.
    a. Establish pre-licensure education standards and certify pre-licensure courses.
    b. Administer and monitor continuing education requirements on insurance producers.
    c. Establish and operate system for licensure of insurance producers, including resident and non-resident producers.

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d. Regulate the business conduct of licensees.

e. Take such disciplinary actions as are appropriate for violations of the insurance laws and regulations of the state by licensees.

4. Review rate filings for rate increases proposed by health insurance companies to ensure rates are not excessive, inadequate, or unfairly discriminatory.
    a. Set standards for filing of rate and form changes.
    b. Review rate filings to ensure mathematical and actuarial accuracy.
    c. Evaluate rate filings as to compliance with state laws and standards.
5. Require certification that health insurer's forms, including policies, riders, addendums, etc. comply with Colorado requirements.
6. Take enforcement actions against entities which are not in compliance with state law and regulation, including:
    a. Unauthorized (unlicensed) entities operating outside the laws of Colorado; and
    b. Entities which assume unauthorized insurance risk, including providers of health care benefits.
7. Require compliance with state statutes and regulations on unfair competition and deceptive practices, including:
    a. Renewability of health coverage;
    b. Required provisions in individual and group health insurance contracts;
    c. Coordination of benefit;
    d. Network adequacy;
    e. Certain aspects of contractual relations with providers.
8. Examine health insurance companies through market conduct examinations to ensure compliance with laws, regulations, policy terms and business practices.
9. Assist consumers with questions and complaints arising from their health insurance coverage or their health insurance company or producer's handling of their application, claim, coverage, or other actions.
    a. Ensure compliance with statutorily required internal claims denial review procedures and adminster external review processes.
    b. Require compliance with mandated health insurance benefits provisions, administrative procedures, contract and network requirements.
    c. Monitor compliance with statutory requirements in such areas as:
        i. Continuation and coversion coverage;
        ii. Pre-existing condition provisions;
        iii. Small group market requirements;
        iv. Access to prescription drugs and required information on prescription information cards;
        v. CoverColorado (high risk pool) and new federal Pre-existing Condition Insurance Program (Getting US Covered);

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vi. Business practices (including uniform claims forms, prompt payment requirements, standardized identification cards, etc.);
vii. Insurance forms requirements, including rate regulation, policy forms, evidences of coverage, benefits ratios (medical loss ratios), provider availability, and disclosures, identification cards; and
viii. Fair marketing standards.

10. Transparency and reporting of information:
    a. Issuance of regular reports on aspects of the health insurance coverage marketplace, including:
        i. Health Cost Report
        ii. Small Group Activity Report
        iii. Annual Report on Complaints Against Insurers
        iv. Complaint Index
        v. Statistical Report
        vi. Report on Denial of (health) Benefits – 2nd level Internal and External Appeals
        vii. Average reimbursement rates for hospital charges
        viii. Consumer Guide to Insurance
11. The Division also has had regulatory responsibilities for the following entities and arrangements:
    a. Multiple Employer Welfare Arrangements (those grandfathered – general authority repealed);
    b. Health Care Coverage Cooperatives (authority repealed);
    c. Health Maintenance Organizations; and
    d. Limited Service Limited Provider Networks.

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