Colorado Revised Statutes 2025

TITLE 10

INSURANCE

Cross references: For insurance under the "Uniform Consumer Credit Code - Insurance", see article 4 of title 5; for liability insurance for state and county employees, see article 14 of title 24; for requirements for companies writing compensation insurance, see article 44 of title 8; for professional liability insurance for professional service corporations for the practice of law, see C.R.C.P. 265.

Law reviews: For article, "Declaratory Judgment Actions to Resolve Insurance Coverage Questions", see 18 Colo. Law. 2299 (1989); for discussion of Tenth Circuit decisions dealing with insurance law, see 66 Den. U. L. Rev. 775 (1989); for discussion of Tenth Circuit decisions dealing with insurance law, see 67 Den. U. L. Rev. 747 (1990).

GENERAL PROVISIONS

ARTICLE 1

General Provisions

Editor's note: This article was repealed in 2002 and was subsequently recreated and reenacted in 2003, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this article prior to 2002, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated.

PART 1

GENERAL PROVISIONS

10-1-101. Legislative declaration. The general assembly finds and declares that the purpose of this title is to promote the public welfare by regulating insurance to the end that insurance rates shall not be excessive, inadequate, or unfairly discriminatory, to give consumers thereof the greatest choice of policies at the most reasonable cost possible, to permit and encourage open competition between insurers on a sound financial basis, and to avoid regulation of insurance rates except under circumstances specifically authorized under the provisions of this title. Such policy requires that all persons having to do with insurance services to the public be at all times actuated by good faith in everything pertaining thereto, abstain from deceptive or misleading practices, and keep, observe, and practice the principles of law and equity in all matters pertaining to such business.

Source: L. 2003: Entire article RC&RE, p. 587, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-101 as it existed prior to 2002.

10-1-102. Definitions. As used in this title 10, unless the context otherwise requires:

(1) "Actuary" means a person designated by the commissioner as a qualified actuary based on requirements set forth in rules promulgated by the commissioner.

(2) "Admitted assets" includes the investments that are admitted assets of a domestic company under parts 1 and 2 of article 3 and part 4 of article 7 of this title and, in addition thereto, includes:

(a) Those assets defined as admitted by nationally recognized insurance statutory accounting principles; and

(b) Other assets deemed by the commissioner to be available for the payment of losses and claims, at values to be determined by the commissioner.

(3) "Admitted company" or "authorized company" designates companies duly qualified and licensed to transact business in this state, under the provisions of this title. "Nonadmitted companies" or "unauthorized companies" designates companies not licensed to transact business in this state, under the provisions of this title (except article 15) and article 14 of title 24, C.R.S.

(3.5) "Bail insurance company" means an insurer engaged in the business of writing bail bonds through bonding agents and subject to regulation by the division.

(3.7) "Bail recovery" means actions taken by a person other than a peace officer to apprehend an individual or take an individual into custody because of the individual's failure to comply with bail conditions.

(4) "Charitable gift annuity" means an annuity that:

(a) Meets the definition and standards contained in section 501 (m)(5) of the federal "Internal Revenue Code of 1986", as amended;

(b) Contains on its face the following statement: "This annuity is not issued by an insurance company nor regulated by the Colorado division of insurance and is not protected by any state guaranty fund or protective association."

(c) Is issued or guaranteed by an organization that at all times during the three years preceding the date of the issuance of such annuity:

(I) Was qualified to receive contributions described in section 170 (c) of the federal "Internal Revenue Code of 1986", as amended; and

(II) If required as a condition of such qualification by provisions of the federal "Internal Revenue Code of 1986", as amended, was in receipt of notification from the federal internal revenue service that such organization was so qualified.

(5) "Commissioner" or "insurance commissioner" means the commissioner of insurance.

(6) (a) "Company", "corporation", "insurance company", or "insurance corporation" includes all corporations, associations, partnerships, or individuals engaged as insurers in the business of insurance, including the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange, or suretyship except fraternal or benevolent orders and societies.

(b) "Company", "corporation", "insurance company", or "insurance corporation" does not include health maintenance organizations unless the specific provision of law by its terms applies to health maintenance organizations.

(c) For the purposes of a "company", "corporation", or "insurance company", a reciprocal insurer shall be considered a single economic entity.

(6.5) "Disqualified insurance company" means a company licensed as a captive insurance company under the laws of this state or the laws of another jurisdiction with gross receipts for the taxable year that consist fifty percent or less of premiums from arrangements that constitute insurance for federal income tax purposes.

(7) "Division" means the division of insurance.

(8) "Domestic" designates those companies incorporated or formed in this state.

(9) "Foreign", when used without limitation, includes all those companies formed by authority of any other state or government.

(10) "Institution" means any entity including, but not limited to, a corporation, a joint-stock company, a limited liability company, an association, a bank, a trust, a partnership, a joint venture, a special district, a government, or a quasi-governmental agency.

(11) "Insurable interest in property" means every interest in property or any relation thereto, or liability in respect thereof, of such a nature that a contemplated peril might directly damnify the insured.

(12) "Insurance" means a contract whereby one, for consideration, undertakes to indemnify another or to pay a specified or ascertainable amount or benefit upon determinable risk contingencies, and includes annuities.

(13) "Insurer" means every person engaged as principal, indemnitor, surety, or contractor in the business of making contracts of insurance.

(14) "Motor vehicle rental agreement" means an agreement for the rental of a motor vehicle for transportation purposes, for a period of no more than ninety days, in return for a fee that is calculated on a daily, weekly, or monthly basis.

(15) "Motor vehicle rental company" means an entity that is in the business of renting, pursuant to motor vehicle rental agreements, motor vehicles that do not come within the definition of a commercial motor vehicle as set forth in section 42-2-402 (4), C.R.S.

(16) "Nonadmitted assets" includes, but is not limited to, those assets defined as nonadmitted by nationally recognized insurance statutory accounting principles. Nonadmitted assets shall not be taken into account in determining the financial condition of a company.

(17) (a) "Qualified United States financial institution" means an institution that is:

(I) Organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof; and

(II) Regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks, trust companies, or savings and loan associations.

(b) If any qualified United States financial institution issues letters of credit, such institution shall have been determined by either the commissioner or the securities valuation office of the national association of insurance commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(c) If any qualified United States financial institution operates a trust, such institution shall be eligible to operate as a fiduciary of a trust and shall have been granted authority to operate with fiduciary powers.

(18) "Real estate" and "real property" include fee simple and leasehold estates therein.

(19) "Transact" as applied to insurance means and includes any of the following:

(a) Solicitation and inducement;

(b) Negotiations preliminary to effectuation of a contract of insurance;

(c) Execution of a contract of insurance;

(d) Transaction of matters subsequent to effectuation of a contract of insurance and arising out of the contract obligations.

Source: L. 2003: Entire article RC&RE, p. 587, § 1, effective July 1. **L. 2004:** (3) amended, p. 897, § 5, effective May 21. **L. 2012:** (3) amended and (3.5) and (3.7) added, (HB 12-1266), ch. 280, p. 1491, § 1, effective July 1. **L. 2021:** IP amended and (6.5) added, (HB 21-1311), ch. 298, p. 1785, § 11, effective June 23.

Editor's note: This section is similar to former § 10-1-102 as it existed prior to 2002.

Cross references: For the legislative declaration in HB 21-1311, see section 1 of chapter 298, Session Laws of Colorado 2021.

10-1-103. Division of insurance - division of insurance cash fund created - division subject to repeal - repeal of functions. (1) There is established a division of insurance in the department of regulatory agencies. The division of insurance is a **type 1** entity, as defined in section 24-1-105. This division is charged with the execution of the laws relating to insurance and has a supervising authority over the business of insurance in this state. Offices of the division of insurance must be provided in the capitol buildings group at Denver, Colorado. Whenever any law of this state refers to the insurance department of the state of Colorado, the law shall be construed as referring to the division of insurance.

(2) The commissioner of insurance, before incurring any expense for his or her office and the maintenance thereof, exclusive of salaries and wages, shall make requisition therefor upon and receive the approval of the executive director of the department of personnel as required by law.

(3) (a) (I) All direct and indirect expenditures of the division are paid from the division of insurance cash fund, which is hereby created in the state treasury.

(II) All fees collected under sections 8-44-204 (7), 8-44-205 (6), 10-2-413, 10-3-108, 10-3-207, 10-3.5-104, 10-3.5-107, 10-12-106, 10-15-103, 10-16-110 (1) and (2), 10-16-111 (1), 10-16-122.1 (2.5), 10-23-102, 10-23-104, 24-10-115.5 (5), and 29-13-102 (5), not including fees retained under contracts entered into in accordance with section 10-2-402 (5) or 24-34-101, and all taxes collected under section 10-3-209 (4) designated for the division of insurance, are transmitted to the state treasurer, who shall credit the money to the division of insurance cash fund.

(b) The division shall use all money credited to the division of insurance cash fund as provided in this section and in section 24-48.5-106, subject to annual appropriation by the general assembly, for the purposes authorized in this title 10 and as otherwise authorized by law.

(c) Money in the fund does not revert to the general fund or to any other fund. In accordance with section 24-36-114, all interest derived from the deposit and investment of money in the fund is credited to the general fund.

(3.5) Repealed.

(4) The division of insurance shall adopt a seal with the words "commissioner of insurance of the state of Colorado" and such other design as the commissioner may prescribe engraved thereon, by which it shall authenticate its proceedings, and of which the courts of this state shall take judicial notice. All copies of papers, certified by the commissioner and sealed with the seal of the division, shall have the same force and validity as the originals thereof in any suit or proceeding in any court in this state.

(5) The office of the division of insurance is a public office. Except as otherwise provided by law, the documents, materials, and information of the office or on file in the office are public records of this state, and information shall be furnished to anyone applying for the information; except that documents, materials, and information provided by the regulatory officials of any state, federal agency, or foreign country and by the national association of insurance commissioners shall be given confidential treatment if such documents, materials, and information are treated as confidential in such other state or foreign country or by such other federal agency or the national association of insurance commissioners. Notwithstanding any provision of this subsection (5) to the contrary, the commissioner or the commissioner's designee may share otherwise confidential documents, materials, and information with regulatory officials of any state, federal agency, or foreign country and with the national association of insurance commissioners if the association or the regulatory official of the other state, federal agency, or foreign country agrees and has the legal authority to maintain the same level of confidentiality as applies to the documents, materials, and information under Colorado law.

(6) (a) The provisions of section 24-34-104, C.R.S., concerning the termination schedule for regulatory bodies of this state, unless extended as provided in that section, are applicable to the division of insurance created by this section.

(b) (I) (A) Repealed.

(B) (Deleted by amendment, L. 2006, p. 75, § 1, effective March 27, 2006.)

(B.5) and (C) (Deleted by amendment, L. 2010, (HB 10-1220), ch. 197, p. 849, § 1, effective July 1, 2010.)

(D) Except as otherwise provided in section 24-34-104 (31)(a)(I), the functions of the division of insurance are repealed, effective September 1, 2030, pursuant to this section and section 24-34-104.

(E) (Deleted by amendment, L. 2010, (HB 10-1220), ch. 197, p. 849, § 1, effective July 1, 2010.)

(II) Prior to such repeal, the division of insurance shall be reviewed as provided for in section 24-34-104, C.R.S.

Source: L. 2003: Entire article RC&RE, p. 590, § 1, effective July 1. **L. 2004:** (3) amended, p. 1253, § 2, effective May 27. **L. 2005:** (6) amended, p. 761, § 11, effective June 1. **L. 2006:** (6)(b)(I)(B) and (6)(b)(I)(D) amended and (6)(b)(I)(B.5) and (6)(b)(I)(E) added, p. 75, § 1, effective March 27; (5) amended, p. 959, § 2, effective January 1, 2007. **L. 2007:** (6)(b)(I)(B.5) amended, p. 339, § 1, effective July 1. **L. 2008:** (6)(b)(I)(C) amended, p. 209, § 1, effective March 26. **L. 2010:** (6)(b)(I)(A), (6)(b)(I)(B.5), (6)(b)(I)(C), (6)(b)(I)(D), and (6)(b)(I)(E) amended, (HB 10-1220), ch. 197, p. 849, § 1, effective July 1. **L. 2012:** (3) and (6)(b)(I)(D) amended and (6)(b)(I)(A) repealed, (HB 12-1266), ch. 280, p. 1491, § 2, effective July 1. **L. 2016:** (6)(b)(I)(D) amended, (HB 16-1192), ch. 83, p. 232, § 5, effective April 14. **L. 2017:** (6)(b)(I)(D) amended, (SB 17-249), ch. 283, p. 1544, § 2, effective June 1; (5) amended,

(HB 17-1231), ch. 284, p. 1575, § 14, effective January 1, 2018. **L. 2020:** (3.5) added, (HB 20-1406), ch. 178, p. 811, § 5, effective June 29. **L. 2021:** (3.5) repealed, (SB 21-266), ch. 423, p. 2795, § 7, effective July 2. **L. 2022:** (1) amended, (SB 22-162), ch. 469, p. 3390, § 101, effective August 10. **L. 2023:** (3) amended, (HB 23-1227), ch. 160, p. 698, § 8, effective August 7.

Editor's note: This section is similar to former § 10-1-103 as it existed prior to 2002.

Cross references: (1) For the legislative declaration contained in the 2006 act amending subsection (5), see section 1 of chapter 211, Session Laws of Colorado 2006.

(2) For the short title (the "Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 22-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

10-1-104. Commissioner of insurance - other employees. (1) The commissioner of insurance is the head of the division of insurance. The commissioner shall be appointed by, and serve at the pleasure of, the governor, subject to confirmation of the appointment by the senate pursuant to section 23 of article IV of the state constitution. The commissioner shall be a person well versed in insurance, and an elector of the state of Colorado, and shall have no pecuniary interest in any insurance company or agency directly or indirectly other than as a policyholder.

(2) The commissioner shall have such employees as may be required for the transaction of the business of the office of the commissioner. One or more shall be deputy commissioners of insurance who are authorized in all matters to act as and for the commissioner of insurance in the absence of the commissioner. Examiners shall be classified as senior and junior. A senior examiner shall have had three full years' experience in the examination of insurance companies as an employee of a state insurance department. The salary and term of office of the commissioner and the employees of the division shall be fixed pursuant to section 13 of article XII of the state constitution.

Source: L. 2003: Entire article RC&RE, p. 592, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-104 as it existed prior to 2002.

10-1-105. Actuary. The commissioner may maintain in the division an actuary who is experienced, skilled, and fully competent to perform the actuarial duties of the division and to assist in or take charge of examinations of insurance companies under the general direction of the commissioner.

Source: L. 2003: Entire article RC&RE, p. 592, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-106 as it existed prior to 2002.

Cross references: For the oath required of an actuary, see § 10-1-106.

10-1-106. Oath required of insurance commissioner and actuary. The commissioner and the actuary, before entering upon their duties, shall take and subscribe to the oath required by the constitution of Colorado, which oath shall be filed in the office of the secretary of state.

Source: L. 2003: Entire article RC&RE, p. 592, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-105 as it existed prior to 2002.

Cross references: For the oath of office, see Colo. Const., art. XII, § 8.

10-1-107. Personal fees prohibited. Neither the commissioner nor any of the commissioner's employees shall be directly or indirectly employed by any insurance company, association, or society, in any capacity, or be directly or indirectly interested in any such insurance corporation, except as a policyholder; nor shall they or any of them charge any such insurance corporation or official any fee or take any valuable thing in payment for any service or otherwise, unless payment for such service is specifically authorized by law. The penalty for violation of this section shall be removal from office.

Source: L. 2003: Entire article RC&RE, p. 592, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-107 as it existed prior to 2002.

Cross references: For the official fees to be paid by insurance companies, see § 10-3-207.

10-1-108. Duties of commissioner - reports - publications - fees - disposition of funds - adoption of rules - examinations and investigations. (1) It is the duty of the commissioner to:

(a) File in offices of the division, and safely keep, all books and papers required by law to be filed therein and to keep and preserve in permanent form a full record of the commissioner's proceedings, including a concise statement of the condition of such insurance companies reported to or examined by the commissioner;

(b) Issue certificates of authority to transact insurance business to any insurance companies that fully comply with the laws of this state;

(c) Issue such other certificates as required by law in the organization of insurance companies and the transaction of the business of insurance; and

(d) Generally, do and perform with justice and impartiality all such duties as are or may be imposed on the commissioner by the laws in relation to the business of insurance in this state.

(2) The commissioner shall require every domestic insurance company to keep its books, records, accounts, and vouchers in such a manner that the commissioner or the commissioner's authorized representatives may readily verify its annual statements and ascertain whether the company is solvent and has complied with the provisions of law. The commissioner shall annually make a tabular statement and synopsis of the several statements as accepted by the commissioner.

(3) The commissioner shall furnish to all insurance companies doing business in this state blanks for the filing of statements as required by law. The commissioner, on retiring from office, shall deliver to his or her qualified successor all furniture, papers, and property pertaining to the commissioner's office.

(4) It is the duty of the commissioner to examine all requests and applications for licenses to be issued under the authority of part 4 of article 2 of this title, and the commissioner is authorized to refuse to issue any such licenses until the commissioner is satisfied of the qualifications and general fitness of the applicant in accordance with the requirements of the insurance laws.

(5) It is the duty of the commissioner to make such investigations and examinations as are authorized by this title (except article 15) and article 14 of title 24, C.R.S., and to investigate such information as is presented to the commissioner by authority that the commissioner believes to be reliable pertaining to violation of the insurance laws of Colorado, and it is the commissioner's duty to present the result of such investigations and examinations for further investigation and prosecution to either the district attorney of the proper judicial district or the attorney general when, in the commissioner's opinion, such violations justify such action.

(6) Any publication circulated in quantity outside the executive branch shall be issued in accordance with the provisions of section 24-1-136, C.R.S.

(7) (a) It is the duty and responsibility of the commissioner to supervise the business of insurance in this state to assure that it is conducted in accordance with the laws of this state and in such a manner as to protect policyholders and the general public.

(b) In complying with this subsection (7), the commissioner shall:

(I) Encourage the fair treatment of health-care providers, including primary care providers;

(II) Encourage policies and developments, including increased investments in primary care, that decrease health disparities and improve the quality, efficiency, and affordability of health-care service delivery and outcomes; and

(III) View the health-care system as a comprehensive entity and encourage and direct health insurers toward policies that advance the welfare of the public through overall efficiency, affordability, improved health-care quality, and appropriate access.

(8) It is the duty of the commissioner to examine all requests and applications from insurers for certificates of authority to be issued pursuant to section 10-3-105. The commissioner is authorized to refuse to issue any such certificates of authority until the commissioner is reasonably satisfied as to the qualifications and general fitness of the insurer to comply with the requirements of the provisions of this title (except article 15) and article 14 of title 24, C.R.S.

(9) It is the duty of the commissioner to transmit all surcharges, costs, taxes, penalties, and fines collected by the division of insurance under any provision of this title (except article 15) and article 14 of title 24, C.R.S., to the department of the treasury. All funds so transmitted shall be credited to the general fund; except that any funds collected by the commissioner as reimbursement for out-of-state travel costs in conjunction with the examination of an insurance company or with an activity to improve regulation of insurance companies are hereby continuously appropriated to the division of insurance in addition to any other funds appropriated for its normal operation.

(10) It is the duty of the commissioner to encourage the dissemination to the public of general information concerning insurance by those engaged in the business of insurance, so as to work toward informed choices of insurance needs and options.

(11) It is the duty of the commissioner to evaluate insurance policies for long-term care to determine their compliance with the provisions of article 19 of this title and to provide insurance companies with a written statement indicating the results of such determination.

(12) It is the duty of the commissioner to oversee the operation of electronic data interchange projects for purposes of uniform billing and electronic data exchange for health benefit coverages in Colorado. In carrying out such duties, the commissioner shall coordinate with the departments of labor and employment, public health and environment, and health care policy and financing, as appropriate.

(13) (a) If determined appropriate for purposes of licensure of provider networks and individual providers as provided in section 6-18-302 (1)(b), C.R.S., the commissioner may adopt rules after consultation with providers and other appropriate persons that set forth standards or requirements specific to licensed provider networks or licensed individual providers concerning solvency and operational capacity or the performance of services consistent with the extent of risk being accepted by the licensed provider network or licensed individual provider.

(b) In determining the need for and the content of such rules, the commissioner shall take into consideration:

(I) The differences between licensed provider networks or licensed individual providers and the type, amount, and extent of risk they accept and services they provide as compared with that accepted by traditional sickness and accident insurers, nonprofit hospital, medical-surgical, and health service corporations, and health maintenance organizations;

(II) The types of information the commissioner would need to assess a provider network or individual provider's ability to accept and manage risk and monitor material changes in the financial solvency or operational capabilities of a provider network or individual provider;

(III) The need to protect consumers, monitor the financial solvency of licensed provider networks and licensed individual providers, and assure the provision of services to consumers, including reasonable access to coverage, according to contractual obligations; and

(IV) Whether such rules would give a licensed provider network or licensed individual provider an unreasonable competitive advantage or disadvantage as compared to traditional insurers, nonprofit hospital, medical-surgical, and health service corporations, and health maintenance organizations offering similar products under similar circumstances.

(c) The commissioner may also consider whether rates are excessive, inadequate, or unfairly discriminatory.

(d) The commissioner may establish a fee to cover the direct and indirect costs of the regulation of provider networks pursuant to the provisions of this subsection (13) and part 3 of article 18 of title 6, C.R.S.

Source: L. 2003: Entire article RC&RE, p. 593, § 1, effective July 1. **L. 2004:** (5), (8), and (9) amended, p. 897, § 6, effective May 21. **L. 2012:** (5), (8), and (9) amended, (HB 12-1266), ch. 280, p. 1492, § 3, effective July 1. **L. 2019:** (7) amended, (HB 19-1233), ch. 194, p. 2121, § 3, effective May 16.

Editor's note: This section is similar to former § 10-1-108 as it existed prior to 2002.

Cross references: For the legislative declaration in HB 19-1233, see section 1 of chapter 194, Session Laws of Colorado 2019.

10-1-109. Rules of commissioner. (1) The commissioner may establish, and from time to time amend, such reasonable rules as are necessary to enable the commissioner to carry out the commissioner's duties under the laws of the state of Colorado.

(2) The commissioner shall adopt rules to ensure that payments to the subsequent injury fund created in section 8-46-101, C.R.S., the workers' compensation cash fund, created in section 8-44-112 (7), C.R.S., the cost containment fund created in section 8-14.5-108, C.R.S., and the major medical insurance fund created in section 8-46-202, C.R.S., from surcharges on premiums paid for policies of workers' compensation insurance that feature deductibles in excess of the limit set forth in section 8-44-111 (1), C.R.S., reflect the value of any reduction in premium achieved through the use of such deductibles. Such rules shall apply only to claims made on policies issued or renewed after the effective date of the rules. In adopting such rules, the commissioner shall determine the most effective method of establishing the value of deductibles in excess of such limits and ensuring that payments reflect such value.

Source: L. 2003: Entire article RC&RE, p. 595, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-109 as it existed prior to 2002.

Cross references: For the rule-making procedures, see article 4 of title 24.

10-1-110. Grounds and procedure for suspension or revocation of certificate or license of entities. (1) The certificate of authority of an insurance company to do business in this state may be revoked or suspended by the commissioner for any reason specified in this title and article 14 of title 24, C.R.S. Specifically, the certificate may be suspended or revoked by the commissioner for reasons that include, but are not limited to:

(a) Insolvency or impairment, as defined in section 10-3-212;

(b) Failure to meet the requirements of section 10-3-201;

(c) Refusal or failure to submit an annual report, as required by section 10-3-109, or any other report required by law or by lawful order of the commissioner;

(d) Doing an unauthorized insurance business in another state, as set forth in section 10-1-117;

(e) Failure to comply with the provisions of its own charter or bylaws, if such failure renders its operation hazardous to the public or to its policyholders;

(f) Failure to submit to examination or any legal obligation relative thereto;

(g) Refusal to pay the cost of examination, as authorized by law;

(h) Use of methods that, although not otherwise specifically proscribed by law, nevertheless render its operation hazardous, or its condition unsound, to the public or to its policyholders;

(i) Failure to otherwise comply with the law of this state, if such failure renders its operation hazardous to the public or to its policyholders;

(j) Use of practices or existence of conditions that render its financial position unsound to the public or its policyholders.

(2) If the commissioner finds upon examination, hearing, or other evidence that any foreign or domestic insurance company has committed any of the acts specified in subsection (1) of this section, or any other act specified in this title and article 14 of title 24, C.R.S., for which the penalty is suspension or revocation of the certificate of authority, the commissioner may suspend or revoke such certificate of authority, if he or she deems it in the best interest of the public and the policyholders of the company, notwithstanding any other provision of said references. Notice of any revocation shall be published in one or more daily newspapers in Denver that have a general state circulation. Before suspending or revoking any certificate of authority of an insurance company, the commissioner shall grant the company fifteen days in which to show cause why such action should not be taken. Any final decision of the commissioner to suspend or revoke a certificate of authority or license of any person or entity regulated by the division of insurance shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

(3) If the commissioner suspends the license or certificate of authority of any entity regulated by the division of insurance, such license or certificate may be revoked one year after the date of suspension if the reason for such suspension is not corrected by the entity. The suspension or revocation of a license or certificate of authority of any entity regulated by the division of insurance shall automatically result in the suspension or revocation, as appropriate, of any license of any insurance agent of any such entity.

(4) If the commissioner finds upon examination or other evidence that any foreign or domestic insurance company has committed any act specified in subsection (1) of this section, the commissioner after notice and hearing may issue an order requiring that the insurance company cease and desist committing such act. If the commissioner believes an emergency exists, the commissioner may enter a cease-and-desist order at once, and a hearing shall be held as soon as practicable. Pending such hearing and decision thereon, the emergency order shall remain in effect subject to the power of the commissioner on the commissioner's own motion or on petition to vacate such order.

Source: L. 2003: Entire article RC&RE, p. 596, § 1, effective July 1. **L. 2012:** IP(1) and (2) amended, (HB 12-1266), ch. 280, p. 1493, § 4, effective July 1.

Editor's note: This section is similar to former § 10-1-111 as it existed prior to 2002.

10-1-111. Invoking aid of courts. The commissioner, through the attorney general, may invoke the aid of the courts through injunction or other proper process, mandatory or otherwise, to enforce any proper order made by the commissioner or action taken by the commissioner; but nothing in this title (except article 15) and article 14 of title 24, C.R.S., shall be construed to prevent the company or person affected by any order, ruling, proceeding, act, or action of the commissioner, or any person acting on behalf and at instance of the commissioner, from testing the validity of the same in any court of competent jurisdiction, through injunction, appeal, or other proper process or proceeding, mandatory or otherwise.

Source: L. 2003: Entire article RC&RE, p. 597, § 1, effective July 1. **L. 2004:** Entire section amended, p. 898, § 7, effective May 21. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1493, § 5, effective July 1.

Editor's note: This section is similar to former § 10-1-112 as it existed prior to 2002.

10-1-112. Policy conditions required by other states. The policies of a domestic insurance company, when issued or delivered in any other state, territory, district, or country, may contain any provision required by the laws of the state, territory, district, or country in which the same are issued, anything in this title (except article 15) and article 14 of title 24, C.R.S., to the contrary notwithstanding.

Source: L. 2003: Entire article RC&RE, p. 597, § 1, effective July 1. **L. 2004:** Entire section amended, p. 898, § 8, effective May 21. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1493, § 6, effective July 1.

Editor's note: This section is similar to former § 10-1-115 as it existed prior to 2002.

10-1-113. No seal required on policies. All policies or contracts made or entered into by any domestic company may be made with or without the seal thereof. The policies or contracts shall be subscribed by the president or such other officers as may be designated by the bylaws for that purpose, and shall be attested by the secretary, and, being so subscribed, shall be obligatory upon such company.

Source: L. 2003: Entire article RC&RE, p. 598, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-116 as it existed prior to 2002.

10-1-114. Sale of premium notes prohibited. It is unlawful for any insurance company or any agent thereof who has accepted a premium note in payment for a policy of insurance to hypothecate, sell, assign, dispose of, or attempt to collect said note prior to the delivery of said insurance policy to the applicant.

Source: L. 2003: Entire article RC&RE, p. 598, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-118 as it existed prior to 2002.

10-1-115. Penalty. If any insurance company or any agent of any such company violates any of the provisions of section 10-1-114, the commissioner has the power and is authorized to revoke the certificate of authority of any company so offending or to cancel the license of any such agent who violates any provisions of section 10-1-114.

Source: L. 2003: Entire article RC&RE, p. 598, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-119 as it existed prior to 2002.

Cross references: For the revocation of a certificate of authority to do business, see § 10-1-110.

10-1-116. Defamation of other companies - penalty. It is unlawful for any insurance company doing business in this state, or any officer, director, clerk, employee, or agent thereof, to make, verbally or otherwise, publish, print, distribute, or circulate, or cause the same to be done, or in any way to aid, abet, or encourage the making, printing, publishing, distributing, or circulating of any pamphlet, circular, article, literature, or statement of any kind that is defamatory of any other insurance company doing business in this state, or licensed to sell its capital stock within this state, that contains any false and malicious criticism or false and malicious statement calculated to injure such company in its reputation or business. Any officer, director, clerk, employee, or agent of any insurance company violating the provisions of this section commits a petty offense.

Source: L. 2003: Entire article RC&RE, p. 598, § 1, effective July 1. **L. 2021:** Entire section amended, (SB 21-271), ch. 462, p. 3146, § 107, effective March 1, 2022.

Editor's note: This section is similar to former § 10-1-120 as it existed prior to 2002.

Cross references: For the penalty for a petty offense, see § 18-1.3-503.

10-1-117. Company unauthorized in other states. If, upon investigation, the commissioner finds that any insurance company incorporated under the laws of Colorado is doing business in another state or territory without having first procured a license or authority from such state or territory, if any is required, authorizing it to do business therein, the commissioner may revoke the authority of such company to do business in this state.

Source: L. 2003: Entire article RC&RE, p. 598, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-121 as it existed prior to 2002.

Cross references: For the revocation of a certificate of authority to do business, see § 10-1-110.

10-1-118. Foreign companies - unsatisfied judgments - suspension. (1) If a judgment against a foreign insurance company is unsatisfied, and execution has issued on said judgment, and the return of the sheriff discloses that the sheriff cannot fully satisfy such judgment, the judgment creditor or judgment creditor's attorney may file with the commissioner, in triplicate, a complaint setting forth such facts. The commissioner shall mail a copy of such complaint to the home office of such insurance company, at the address shown in the records of the division of insurance, and a copy to the Colorado office or the Colorado general agent of such insurance company.

(2) If said insurance company does not, within thirty days after such mailing, pay and discharge said judgment or show good cause to the commissioner for the failure to pay such judgment, the commissioner, upon satisfactory proof of the allegations of the complaint, shall forthwith suspend the license or right of such insurance company to do business in this state. If good cause, previously shown, ceases to exist and the judgment remains unpaid, the commissioner shall suspend such license or right.

(3) The commissioner shall reinstate the license or right to do business in this state when the insurance company has fully paid such judgment.

Source: L. 2003: Entire article RC&RE, p. 598, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-122 as it existed prior to 2002.

Cross references: For the suspension of a certificate of authority to do business, see § 10-1-110.

10-1-119. Insurance vending machines prohibited. No policy or contract of insurance of any kind shall be sold or dispensed through any mechanical device or vending machine, but this section shall not be construed as to prevent the use of office machines of any type by an insurance company. Insurance shall be sold only by an insurance producer, as defined in section 10-2-103 (6).

Source: L. 2003: Entire article RC&RE, p. 599, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-123 as it existed prior to 2002.

10-1-120. Reporting of medical malpractice claims. (1) Each insurance company licensed to do business in this state and engaged in the writing of medical malpractice insurance for licensed practitioners shall send to the Colorado medical board, in the form prescribed by the commissioner of insurance, information relating to each medical malpractice claim against a licensed practitioner that is settled or in which judgment is rendered against the insured.

(2) The insurance company shall provide such information as is deemed necessary by the Colorado medical board to conduct a further investigation and hearing.

Source: L. 2003: Entire article RC&RE, p. 599, § 1, effective July 1. **L. 2010:** Entire section amended, (HB 10-1260), ch. 403, p. 1977, § 49, effective July 1.

Editor's note: This section is similar to former § 10-1-124 as it existed prior to 2002.

10-1-120.5. Reporting of malpractice claims against nurses. (1) Each insurance company licensed to do business in this state and engaged in writing malpractice insurance for nurses shall send to the state board of nursing, in the form prescribed by the commissioner, information relating to each malpractice claim against a licensed nurse that is settled or in which judgment is rendered against the insured.

(2) The information must include information deemed necessary by the state board of nursing to conduct a further investigation and hearing.

Source: L. 2020: Entire section added, (HB 20-1216), ch. 190, p. 867, § 7, effective July 1.

Cross references: For the legislative declaration in HB 20-1216, see section 1 of chapter 190, Session Laws of Colorado 2020.

10-1-121. Reporting of malpractice claims against physical therapists. (1) Each insurance company licensed to do business in this state and engaged in the writing of malpractice insurance for physical therapists licensed under article 285 of title 12 shall send to the director of the division of professions and occupations, in the department of regulatory agencies, in the form prescribed by the commissioner of insurance, information relating to each claim involving physical therapy malpractice or against any such physical therapist that is settled or in which judgment is rendered against the insured.

(2) Every insurance company licensed to do business in this state that makes payment under a policy of insurance in settlement of a claim of physical therapy malpractice, or in satisfaction of a judgment for such malpractice, shall report to the secretary of health and human services, in accordance with 42 U.S.C. secs. 11131 and 11134, the following information:

(a) The name of any physical therapist for whose benefit the payment is made;

(b) The amount of the payment;

(c) The name, if known, of any hospital with which the physical therapist is affiliated or associated;

(d) A description of the acts or omissions and injuries or illnesses upon which the action or claim was based; and

(e) Such other information as the secretary of health and human services determines is required for appropriate interpretation of the information so reported.

Source: L. 2003: Entire article RC&RE, p. 599, § 1, effective July 1. **L. 2019:** (1) amended, (HB 19-1172), ch. 136, p. 1650, § 29, effective October 1.

Editor's note: This section is similar to former § 10-1-124.2 as it existed prior to 2002.

10-1-122. Reporting of malpractice claims against architects. Each insurance company doing business in this state and engaged in the writing of malpractice insurance for architects shall send to the state board of licensure for architects, professional engineers, and professional land surveyors, in the form prescribed by the commissioner, information relating to each malpractice claim against a licensed architect or a corporation, partnership, or group of persons practicing architecture that is settled or in which judgment is rendered against the insured within ninety days after the effective date of such settlement or judgment.

Source: L. 2003: Entire article RC&RE, p. 600, § 1, effective July 1. **L. 2006:** Entire section amended, p. 741, § 3, effective July 1.

Editor's note: This section is similar to former § 10-1-124.5 as it existed prior to 2002.

Cross references: For the provisions concerning architects, see part 4 of article 120 of title 12.

10-1-123. Reporting of claims against plumbers. Each insurance company licensed to do business in this state and engaged in the writing of insurance for plumbers shall send within ninety days to the examining board of plumbers, in the form prescribed by the commissioner, information relating to each malpractice claim against a licensed plumber that is settled or in which judgment is rendered against the insured.

Source: L. 2003: Entire article RC&RE, p. 600, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-124.6 as it existed prior to 2002.

Cross references: For the provisions concerning plumbers, see article 155 of title 12.

10-1-124. Reporting of podiatric malpractice claims. (1) Each insurance company licensed to do business in this state and engaged in the writing of malpractice insurance for licensed podiatrists shall send to the Colorado podiatry board, in the form prescribed by the commissioner, information relating to each malpractice claim against a licensed podiatrist that is settled or in which judgment is rendered against the insured.

(2) Such information shall include any information deemed necessary by the Colorado podiatry board to conduct a further investigation and hearing.

Source: L. 2003: Entire article RC&RE, p. 600, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-124.7 as it existed prior to 2002.

Cross references: For the provisions concerning podiatrists, see article 290 of title 12.

10-1-125. Reporting of malpractice claims against optometrists. (1) Each insurance company licensed to do business in this state and engaged in the writing of malpractice insurance for optometrists shall send to the state board of optometry, in the form prescribed by the commissioner, information relating to each malpractice claim against a licensed optometrist that is settled or in which judgment is rendered against the insured.

(2) Such information shall include any information deemed necessary by the state board of optometry to conduct a further investigation and hearing.

Source: L. 2003: Entire article RC&RE, p. 601, § 1, effective July 1. **L. 2011:** Entire section amended, (SB 11-094), ch. 129, p. 450, § 28, effective April 22.

Editor's note: This section is similar to former § 10-1-124.9 as it existed prior to 2002.

Cross references: For the provisions concerning optometrists, see article 275 of title 12.

10-1-125.3. Reporting of malpractice claims against pharmacists and pharmacies. (1) Each insurance company licensed to do business in this state and engaged in writing malpractice insurance for licensed pharmacists and registered pharmacies, and each pharmacist or pharmacy that self-insures, shall send to the state board of pharmacy, in the form prescribed

by the commissioner in collaboration with the state board of pharmacy, information relating to each malpractice claim against a licensed pharmacist or registered pharmacy that is settled or in which judgment is rendered against the insured.

(2) The insurance company or self-insured pharmacist or pharmacy shall provide information relating to each malpractice claim that the state board of pharmacy deems necessary to conduct a further investigation and hearing.

Source: L. 2021: Entire section added, (SB 21-094), ch. 314, p. 1944, § 32, effective September 1.

Editor's note: This section is similar to former § 12-280-111 (1) and (2) as they existed prior to 2021. For a detailed comparison of this section, see SB 21-094, L. 2021, p. 1944.

10-1-125.5. Reporting of malpractice claims against naturopathic doctors. Each insurance company licensed to do business in this state and engaged in writing malpractice insurance for naturopathic doctors registered under article 250 of title 12 shall send to the director of the division of professions and occupations in the department of regulatory agencies, in the form prescribed by the commissioner, information relating to each malpractice claim against a registered naturopathic doctor that is settled or in which judgment is rendered against the insured naturopathic doctor. The insurance company shall include any information the director determines necessary to enable the director to conduct a further investigation and hearing.

Source: L. 2017: Entire section added, (SB 17-106), ch. 302, p. 1649, § 6, effective August 9. **L. 2019:** Entire section amended, (HB 19-1172), ch. 136, p. 1650, § 30, effective October 1.

10-1-125.7. Reporting of malpractice claims against audiologists. (1) Each insurance company licensed to do business in this state and engaged in the writing of malpractice insurance for audiologists shall send to the director of the division of professions and occupations in the department of regulatory agencies, in the form prescribed by the commissioner, information relating to each malpractice claim against a licensed audiologist that is settled or in which judgment is rendered against the insured.

(2) The information must include information deemed necessary by the director of the division of professions and occupations in the department of regulatory agencies to conduct a further investigation and hearing.

Source: L. 2020: Entire section added, (HB 20-1219), ch. 300, p. 1493, § 6, effective September 1.

10-1-126. Training program for persons working with the aging. The division of insurance shall develop a training program for persons working with the aging on the local level that will enable them to assist the elderly in dealing with their medicare supplemental insurance problems.

Source: L. 2003: Entire article RC&RE, p. 601, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-125 as it existed prior to 2002.

10-1-127. Discretionary use of administrative law judges. Whenever the commissioner or the division of insurance pursuant to this title or any other provision of law is obligated or authorized to hold a hearing, the commissioner, at his or her discretion, may designate an employee of the division of insurance who has administrative responsibilities to act as a hearing officer or may use the services of an administrative law judge appointed pursuant to part 10 of article 30 of title 24, C.R.S., to conduct the hearing according to the "State Administrative Procedure Act". Any decision by such a designated hearing officer or appointed administrative law judge shall be an initial decision and, in the absence of an appeal to the division of insurance or a review upon motion of the commissioner as provided in section 24-4-105, C.R.S., shall thereupon become the decision of the division of insurance. Any final decision of the commissioner or the division of insurance shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 2003: Entire article RC&RE, p. 601, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-126 as it existed prior to 2002.

Cross references: For the provisions concerning the "State Administrative Procedure Act", see article 4 of title 24.

10-1-128. Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration. (1) For purposes of this title 10, articles 40 to 47 of title 8, articles 200, 215, 220, 240, 245, 255, 270, 275, 285, 290, 300, and 305 of title 12, and article 20 of title 44, a fraudulent insurance act is committed if a person knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, a purported insurer, or any insurance producer any written statement as part or in support of an application for the issuance or the rating of an insurance policy or a claim for payment or other benefit pursuant to an insurance policy that the person knows to contain false information concerning any fact material to the application or claim or if the person knowingly and with intent to defraud or mislead conceals information concerning any fact material related to the application or claim. For purposes of this section, "written statement" includes a client medical record as such term is defined in section 18-4-412 (2)(a) and any bill for medical services.

(2) (a) The general assembly finds and declares that insurance fraud is expensive; that it increases premiums and places businesses at risk; and that it reduces consumers' ability to raise their standards of living and decreases the economic vitality of this state. The general assembly further finds and declares that the state of Colorado must aggressively confront the problem of insurance fraud by facilitating the detection of and reducing the occurrence of fraud through stricter enforcement and deterrence and by encouraging greater cooperation among consumers, the insurance industry, and the state in coordinating efforts to combat insurance fraud.

(b) Colorado has addressed insurance fraud in various statutes, including but not limited to the civil and administrative provisions found in this section, part 4 of article 2 of this title, parts 1, 2, 9, and 11 of article 3 of this title, and numerous other provisions of this title. It has also been addressed in criminal provisions found in parts 1, 2, and 3 of article 2 of title 18, part 1 of article 4 of title 18, part 1 of article 5 of title 18, and section 18-5-205, C.R.S. These statutory provisions impose regulatory oversight and severe civil and criminal penalties on authorized and unauthorized insurance companies and other persons who commit insurance fraud. The purpose of this section is to further improve regulatory oversight of licensed persons who commit insurance fraud and provide additional remedies to aggrieved persons.

(3) An allegation of a fraudulent insurance act shall not excuse an insurance company from its duty to promptly investigate a claim.

(4) (a) Each insurance company licensed to do business in this state that, in a lawsuit involving a fraudulent insurance act, obtains a judgment or settlement against a person who is licensed by the state of Colorado and whose services are compensated in whole or in part, directly or indirectly, by insurance claim proceeds shall send notice of such settlement or judgment to the appropriate Colorado state licensing board, in the form prescribed by the executive director of the department of regulatory agencies. No cause of action shall arise against any insurance company or individual for providing information as provided in this subsection (4).

(b) Every person who, in a lawsuit involving a fraudulent insurance act, obtains a judgment or settlement against a person who is licensed by the state of Colorado and whose services are compensated in whole or in part, directly or indirectly, by insurance claim proceeds, may send to the appropriate Colorado state licensing board notice of such settlement or judgment. No cause of action shall arise against any person for providing information as provided in this subsection (4).

(c) Every person who obtains a judgment or settlement involving a fraudulent insurance act by an insurance company or an agent of an insurance company may send to the Colorado division of insurance within the department of regulatory agencies notice of such judgment or settlement, including any evidence of a fraudulent insurance act. No cause of action shall arise against any person for providing information as provided in this subsection (4).

(5) (a) Every licensed insurance company doing business in Colorado shall prepare, implement, and maintain an insurance anti-fraud plan; except that this subsection (5) shall not apply to entities whose principal business is the assumption of reinsurance, reinsurance agreements, or reinsurance claims transactions. Insurance companies approved by the commissioner under article 5 of this title may be required, as a condition of such approval, to maintain an insurance anti-fraud plan. Each anti-fraud plan shall outline specific procedures, appropriate to the type of insurance provided by the insurance company in Colorado, to:

(I) Prevent, detect, and investigate all forms of insurance fraud, including fraud by the insurance company's employees and agents, fraud resulting from false representations or omissions of material fact in the application for insurance, renewal documents, or rating of insurance policies, claims fraud, and security of the insurance company's data processing systems;

(II) Educate appropriate employees about fraud detection and the company's anti-fraud plan;

(III) Provide for the hiring of or contracting for one or more fraud investigators;

(IV) Report suspected or actual insurance fraud to the appropriate law enforcement and regulatory entities in the investigation and prosecution of insurance fraud.

(b) The commissioner of insurance may review a licensed insurance company's anti-fraud plan in connection with a market conduct examination to determine whether such plan complies with the requirements of paragraph (a) of this subsection (5).

(c) Every licensed insurance company doing business in this state shall include, as part of its annual report as required in section 10-3-109, a summary of its anti-fraud efforts as described in paragraph (a) of this subsection (5).

(d) The anti-fraud plan of an insurance company and the summary of anti-fraud efforts prepared as required in paragraph (c) of this subsection (5) are not public records and are exempted from article 72 of title 24, C.R.S.; are proprietary and not subject to public examination; and are not discoverable or admissible under the Colorado rules of civil procedure in any civil litigation.

(e) Any insurance company or producer of an insurance company that has committed a fraudulent insurance act shall be subject to available disciplinary action by the commissioner of insurance.

(f) The responsibility of an insurance company under this section to prevent, detect, and investigate insurance fraud shall not excuse its duty to comply with section 10-3-1104 or any other applicable insurance law.

(6) (a) Each insurance company shall provide on all printed applications for insurance, or on all insurance policies, or on all claim forms provided and required by an insurance company, or required by law, whether printed or electronically transmitted, a statement, in conspicuous nature, permanently affixed to the application, insurance policy, or claim form substantially the same as the following:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

(b) This subsection (6) shall not apply to reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

Source: L. 2003: Entire article RC&RE, p. 601, § 1, effective July 1. **L. 2006:** (2)(b) amended, p. 1489, § 8, effective June 1. **L. 2019:** (1) amended, (HB 19-1172), ch. 136, p. 1651, § 31, effective October 1. **L. 2020:** (1) amended, (HB 20-1183), ch. 157, p. 695, § 32, effective July 1; (1) amended, (HB 20-1230), ch. 274, p. 1347, § 14, effective September 14. **L. 2022:** (1) amended, (HB 22-1213), ch. 284, p. 2037, § 5, effective August 10.

Editor's note: (1) This section is similar to former § 10-1-127 as it existed prior to 2002.

(2) Amendments to subsection (1) by HB 20-1183 and HB 20-1230 were harmonized.

10-1-129. Fraudulent insurance acts - enforcement. The attorney general shall have concurrent jurisdiction with the district attorneys of this state to investigate and prosecute allegations of criminal conduct related to insurance fraud pursuant to this title and titles 8 and 18, C.R.S. The cost to the attorney general of such investigations and prosecutions shall be paid from fees collected from entities regulated by the division pursuant to section 24-31-104.5, C.R.S.

Source: L. 2003: Entire article RC&RE, p. 604, § 1, effective July 1. **L. 2010:** Entire section amended, (HB 10-1385), ch. 204, p. 883, § 3, effective May 5. **L. 2012:** Entire section amended, (SB 12-110), ch. 158, p. 561, § 5, effective July 1.

Editor's note: This section is similar to former § 10-1-127.5 as it existed prior to 2002.

10-1-130. Availability of sickness, health, and accident insurance. (1) The commissioner shall assess the availability of sickness, health, and accident insurance in Colorado with a view to identifying specific groups of persons to whom such coverage is unavailable by virtue of cost, preexisting condition, or other circumstances.

(2) Repealed.

Source: L. 2003: Entire article RC&RE, p. 604, § 1, effective July 1; entire section amended, p. 2053, § 2, effective August 6.

Editor's note: (1) Subsection (1) is similar to former § 10-1-130 as it existed prior to 2002.

(2) Subsection (2)(d) provided for the repeal of subsection (2), effective July 1, 2010. (See L. 2003, p. 604.)

Cross references: For the legislative declaration contained in the 2003 act amending this section, see section 1 of chapter 322, Session Laws of Colorado 2003.

10-1-131. Duties to third parties - rules. (1) Pursuant to rules promulgated by the commissioner, an insurer shall notify any additional insured by endorsement on a general liability policy, whose interests are affected by a claim, of the results of the insurer's investigation of such claim and the status of the claim within a reasonable period of time as determined by the commissioner. Such notice shall include a statement confirming or denying coverage of the claim and, if coverage is denied, the reasons for denying coverage of the claim or any portion of the claim. In the event coverage has not been determined, a copy of the reservation of rights letter shall constitute sufficient notice.

(2) Failure to notify any additional insured by endorsement on a general liability policy pursuant to this section shall subject the insurer to the provisions of sections 10-3-1108 and 10-3-1109.

(3) The provisions of this section shall not apply to those claims under a general liability policy upon which a lawsuit has been filed.

Source: L. 2003: Entire article RC&RE, p. 604, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-132 as it existed prior to 2002.

10-1-132. Oversight of the general assembly. Nothing in this title shall limit the ability of the general assembly to direct the accounting principles to be used by insurers authorized in this state in order to create uniformity.

Source: L. 2003: Entire article RC&RE, p. 605, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-133 as it existed prior to 2002.

10-1-133. Consumer insurance council - creation - advisory body - appointment of members - meetings - repeal. (1) There is hereby created in the division the consumer insurance council, also referred to in this section as the "council". The council is an advisory body to the commissioner concerning insurance matters of interest to the public. Nothing in this section divests the commissioner of the commissioner's authority to regulate the business of insurance.

(2) (a) The council consists of at least six and not more than fifteen members appointed by the commissioner, all of whom must represent consumer organizations or be consumers who are not engaged, directly or indirectly, in the insurance industry or any other industry, business, or profession that might present a conflict of interest, as determined by the commissioner, and one of whom must be a consumer whose first language is not English. To the greatest extent possible, the council must reflect the geographic and demographic diversity of the state. Insurance producers, insurance industry representatives, actively practicing health-care providers, and any other individuals who may have a conflict of interest, as determined by the commissioner, are not eligible for membership on the council.

(b) The commissioner shall appoint members of the council in a timely manner. Members shall serve two-year terms with a maximum of three consecutive terms.

(c) Three or more unexcused absences of a member of the council constitute grounds for the removal of the member. The chair of the council, in consultation with the commissioner, shall determine whether a member with three or more unexcused absences may continue service on the council. If a member is removed, the commissioner shall appoint a new member to serve the remaining portion of the two-year term.

(d) Members of the council shall serve without compensation but are entitled to reimbursement for actual and necessary expenses incurred in traveling to and from council meetings, including any required dependent care and dependent or attendant travel, food, and lodging expenses.

(3) (a) The council shall elect a chair from its membership. The chair shall serve a one-year term and may be elected to another one-year term.

(b) The council shall elect a vice-chair from its membership. The vice-chair shall serve in the absence of the chair. The vice-chair shall serve a one-year term and may be elected to another one-year term.

(4) (a) The council shall meet quarterly and may request up to four additional meetings per year. All meetings of the council are open to the public. General meetings of the council shall be held at the office of the division. The council may meet in other locations of the state as

agreed upon by the council. Members of the council may participate in meetings via telephonic communications.

(b) A council member may request a special meeting. Requests for special meetings must be made to the chair of the council.

(c) All members of the council may request topics of discussion for the council.

(d) The council must act by consensus.

(e) The council may submit recommendations to the commissioner, including legislative recommendations. If the council submits a recommendation to the commissioner, the commissioner shall provide a response to the council, in a timely manner, regarding the recommendation and how the commissioner will address the recommendation.

(5) This section is repealed, effective September 1, 2029. Before the repeal, the council is scheduled for review in accordance with section 2-3-1203.

Source: L. 2008: Entire section added, p. 158, § 1, effective July 1; (5.5) added, p. 2255, § 8, effective July 1. **L. 2009:** (5.5) and (6) amended, (SB 09-292), ch. 369, p. 1940, § 9, effective August 5. **L. 2019:** Entire section RC&RE, (HB 19-1150), ch. 113, p. 483, § 1, effective August 2. **L. 2024:** (2)(a) amended, (HB 24-1440), ch. 320, p. 2141, § 2, effective May 31.

Editor's note: Subsection (6) provided for the repeal of this section, effective July 1, 2018. (See L. 2008, p. 158.)

10-1-134. Office of insurance ombudsman - plan - report to joint budget committee. On or before September 15, 2008, the commissioner shall present a plan to the joint budget committee of the general assembly regarding the establishment of an office of insurance ombudsman. The plan shall include an assessment of the need to establish the office, a plan to implement the office, and the estimated costs associated with establishing and maintaining the office. The plan shall require the ombudsman to assist consumers with issues related to insurance availability, claims processing, coverage questions, and other matters related to insurance consumer education and assistance.

Source: L. 2008: Entire section added, p. 2247, § 2, effective August 5.

10-1-135. Reimbursement for benefits - limitations - notice - definitions - legislative declaration. (1) The general assembly hereby finds and declares that:

(a) When a payer of benefits seeks repayment of the benefits provided to an injured party, the repayment reduces the amount available to the injured party to compensate him or her for injuries and damages other than the cost of medical care and medical services;

(b) Reimbursement or repayment of benefits should not be permitted when the injured party would not be fully compensated for his or her injuries and damages;

(c) It is in the best interests of the citizens of this state to ensure that each insured injured party recovers full compensation for bodily injury caused by the act or omission of a third party, and that such compensation is not diminished by repayment, reimbursement, or subrogation rights of the payer of benefits;

(d) This law regulating insurance and health benefit plans is intended to ensure that an injured party who recovers damages for bodily injuries caused by a third party and receives benefits pursuant to an insurance policy, contract, or benefit plan is fully compensated for his or her injuries and damages before the payer of benefits may seek repayment of benefits provided to the injured party;

(e) In the absence of this section, payers of benefits may seek repayment of benefits out of a recovery obtained by the injured party without paying attorney fees incurred by the injured party in obtaining the recovery, thereby benefitting from attorney services for which they did not pay;

(f) This section is intended to require a payer of benefits to pay a proportionate share of the attorney fees when the payer of benefits is a beneficiary of the attorney services paid for by the injured party.

(2) As used in this section, unless the context otherwise requires:

(a) "Benefits" means payment or reimbursement of health-care expenses, health-care services, disability payments, lost wage payments, or any other benefits of any kind, including discounts and write-offs, provided to or on behalf of an injured party under a policy of insurance, contract, or benefit plan with an individual or group, whether or not provided through an employer.

(b) "Injured party" means a person who has sustained bodily injury as the result of the act or omission of a third party, has pursued a personal injury or similar claim against the third party or has made a claim under his or her uninsured or underinsured motorist coverage, and has received benefits as a policyholder, participant, or beneficiary from the payer of benefits. "Injured party" includes the personal representative of the estate of an injured party or the legal representative of a person under a disability as provided in article 81 of title 13, C.R.S.

(c) (I) "Payer of benefits" means any insurer, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan, other insurance policy or plan, or any other payer of benefits. "Payer of benefits" includes a fiduciary of an insurer, plan, or other payer of benefits.

(II) "Payer of benefits" does not include a program of medical assistance under the "Colorado Medical Assistance Act", articles 4 to 6 of title 25.5, C.R.S., or the children's basic health plan, as defined in article 8 of title 25.5, C.R.S.

(d) "Recovery" means recovery of a monetary award from a third party through either settlement or judgment to compensate an injured party for bodily injury sustained as a result of an act or omission of the third party. "Recovery" includes benefits paid or settlement of claims under uninsured or underinsured motorist coverage pursuant to section 10-4-609.

(3) (a) (I) Reimbursement or subrogation pursuant to a provision in an insurance policy, contract, or benefit plan is permitted only if the injured party has first been fully compensated for all damages arising out of the claim. Any provision in a policy, contract, or benefit plan allowing or requiring reimbursement or subrogation in circumstances in which the injured party has not been fully compensated is void as against public policy.

(II) This paragraph (a) does not limit the right of an insurer to seek reimbursement or subrogation to recover amounts paid for property damage or the right of an insurer providing uninsured or underinsured motorist coverage pursuant to section 10-4-609 to an injured party to pursue claims against an at-fault third party, and any amounts recovered by such insurer shall not be reduced pursuant to paragraph (c) of this subsection (3).

(b) If the injured party is fully compensated and reimbursement or subrogation of benefits is authorized, the reimbursement or subrogation amount cannot exceed the amount actually paid by the payer of benefits to cover benefits under the policy, contract, or benefit plan or, for health-care services provided on a capitated basis, the amount equal to eighty percent of the usual and customary charge for the same services by health-care providers that provide health-care services on a noncapitated basis in the geographic region in which the services are rendered.

(c) The amount recoverable, if any, by the payer of benefits for reimbursement or subrogation shall be reduced by an amount equal to the payer of benefits' proportionate share of the attorney fees and expenses incurred by or on behalf of the injured party in making the recovery, based on the ratio of the amount of attorney fees and expenses incurred to the amount of the recovery.

(d) (I) If the injured party makes a recovery of an amount that is less than the total amount of coverage available under any third-party liability insurance policy or uninsured or underinsured motorist coverage pursuant to section 10-4-609, there is a rebuttable presumption that the injured party has been fully compensated. If the injured party makes a recovery of an amount equal to the total amount of coverage available under all third-party liability insurance policies and uninsured or underinsured motorist coverages, there is a rebuttable presumption that the injured party has not been fully compensated.

(II) If the injured party obtains a judgment, the amount of the judgment is presumed to be the amount necessary to fully compensate the injured party.

(4) (a) (I) Any disputes between the payer of benefits and the injured party regarding entitlement to reimbursement or subrogation shall be resolved in accordance with this paragraph (a), regardless of whether administrative remedies contained in the policy, contract, or benefit plan documents have been exhausted by the injured party.

(II) If the injured party obtains a recovery that is less than the sum of all damages incurred by the injured party and intends to enforce the requirements of subsection (3) of this section, the injured party shall notify the payer of benefits within sixty days of receipt of each recovery. The notice shall include the total amount and source of the recovery; the coverage limits applicable to any available insurance policy, contract, or benefit plan; and the amount of any costs charged to the injured party. If recovery was obtained through a settlement agreement that contains a confidentiality provision that affects the information required by this subparagraph (II), the confidentiality provision is unenforceable as to the disclosure of the required information.

(III) If the payer of benefits disputes that the injured party's recovery is less than the sum of all damages incurred by the injured party, the dispute shall be resolved by arbitration. The payer of benefits may request arbitration of the dispute to determine the extent to which the payer of benefits may be entitled to share in the recovery pursuant to subsection (3) of this section. The payer of benefits may request arbitration no later than sixty days after receipt of any notice under subparagraph (II) of this paragraph (a).

(IV) If the payer of benefits requests arbitration of the dispute, the injured party and the payer of benefits shall jointly choose an arbitrator to resolve the dispute. If the injured party and the payer of benefits cannot agree on an arbitrator, the dispute shall be resolved by a panel of three arbitrators selected as follows:

(A) The injured party shall select one arbitrator;

(B) The payer of benefits shall select one arbitrator; and

(C) The arbitrators chosen by the parties pursuant to sub-subparagraphs (A) and (B) of this subparagraph (IV) shall select the third arbitrator.

(b) If the arbitrator determines that the amount of the recovery does not fully compensate the injured party for his or her damages, the payer of benefits shall have no right to repayment, reimbursement, or subrogation.

(5) A payer of benefits shall not deny or refuse to provide any plan benefits otherwise available to an injured party because of the existence of a potential personal injury or similar claim or the resolution of a personal injury or similar claim.

(6) (a) (I) Except as provided in subparagraph (II) of this paragraph (a), a payer of benefits shall not bring a direct action for subrogation or reimbursement of benefits against a third party allegedly at fault for the injury to the injured party or an insurer providing uninsured motorist coverage.

(II) If an injured party has not pursued a claim against a third party allegedly at fault for the injured party's injuries by the date that is sixty days prior to the date on which the statute of limitations applicable to the claim expires, a payer of benefits may bring a direct action for subrogation or reimbursement of benefits against an at-fault third party. Nothing in this subparagraph (II) precludes an injured party from pursuing a claim against the at-fault third party after the payer of benefits brings a direct action pursuant to this subparagraph (II), and the payer of benefits' right to reimbursement or subrogation is limited by subsection (3) of this section.

(b) A third party shall not include a payer of benefits that is claiming repayment or reimbursement pursuant to subsection (3) of this section as a copayee on any check or draft in payment of a settlement with or judgment for or on behalf of the injured party.

(7) (a) A payer of benefits shall not delay, withhold, or otherwise reduce benefits:

(I) Because the obligation to pay benefits results from an act or omission for which a third party may be liable; or

(II) As a means of enforcing or attempting to enforce a claim for reimbursement or subrogation.

(b) Nothing in this subsection (7) prohibits the coordination of benefits between or among payers of benefits.

(8) When a payer of benefits obtains reimbursement of benefits paid in accordance with this section, the payer of benefits shall apply the amount of the reimbursement as a credit against any lifetime maximum benefit contained in the policy, plan, or contract under which the benefits were paid.

(9) Any language in an insurance policy, contract, or benefit plan that is contrary to this section is void and unenforceable. Although such language is unenforceable, nothing in this section requires an insurer to modify and refile with the commissioner, prior to the standard filing date, an insurance policy, contract, or benefit plan that contains language that is contrary to this section.

(10) Nothing in this section modifies:

(a) The requirement of section 13-21-111.6, C.R.S., regarding the reduction of damages based on amounts paid for the damages from a collateral source. The fact or amount of any collateral source payment or benefits shall not be admitted as evidence in any action against an alleged third-party tortfeasor or in an action to recover benefits under section 10-4-609.

(b) Lien rights of hospitals pursuant to section 38-27-101, C.R.S., or of the department of health care policy and financing pursuant to section 25.5-4-301 (5), C.R.S.; or

(c) Subrogation and lien rights granted to workers' compensation carriers or self-insured employers pursuant to section 8-41-203, C.R.S.

Source: L. 2010: Entire section added, (HB 10-1168), ch. 164, p. 575, § 1, effective August 11.

10-1-136. Insurance policies - language other than English - increasing access for non-English-speaking consumers - definitions. (1) An insurer may conduct transactions in a language other than English.

(2) An insurer authorized to offer insurance in this state may provide insurance policies, endorsements, riders, and any explanatory or advertising materials in a language other than English. If an insurer opts to provide an insurance policy, endorsement, or rider to the customer in a language other than English, the insurer must also provide the English version at the same time. In the event of a dispute or complaint regarding the insurance or advertising materials, the English language version of the insurance document controls the resolution of the dispute or complaint.

(3) (a) A non-English-language policy delivered or issued for delivery in this state is deemed to comply with articles 4 and 16 of this title 10 if the insurer certifies that the policy is translated:

(I) From an English-language policy that complies with this title 10;

(II) Correctly; and

(III) By a certified translator who has certified that the policy is correctly translated or, if a certified translator is not available to translate the policy from English into a language for which the American Translators Association certifies translators, by a qualified translator who has certified that the policy is correctly translated.

(b) An insurer shall maintain copies of all translated policies, endorsements, riders, and any explanatory or advertising materials and make them available for review by the commissioner upon request.

(3.5) The commissioner shall use councils established within the division, including the producer advisory council and any other councils established by the commissioner, to engage with bilingual insurance producers to discuss the insurance market for non-English-speaking consumers, including ways to increase access to insurance products and services for non-English-speaking consumers.

(4) As used in this section:

(a) "American Translators Association" means the national, nonprofit professional association, or its successor organization, that offers certification for translators.

(b) "Certified translator" means an individual who is certified as a translator by the American Translators Association.

Source: L. 2013: Entire section added, (HB 13-1233), ch. 17, p. 622, § 31, effective August 7. **L. 2014:** (2) amended, (HB 14-1282), ch. 128, p. 452, § 1, effective August 6. **L. 2023:** (3) amended and (4) added, (HB 23-1004), ch. 64, p. 228, § 1, effective January 1, 2024. **L. 2024:** (3.5) added, (HB 24-1440), ch. 320, p. 2142, § 3, effective May 31.

10-1-137. Electronic delivery of documents - when permitted - definitions - consent - construction with other laws. (1) As used in this section, unless the context otherwise requires:

(a) Delivered or delivery "by electronic means" to a party includes:

(I) Delivery to an electronic mail address at which the party has consented to receive notices or documents; and

(II) Posting on an electronic network or website accessible to the party via the internet, mobile application, computer, mobile device, tablet, or any other electronic device if the party is given separate notice of the posting by either:

(A) Electronic mail to the electronic mail address at which the party has consented to receive notice; or

(B) Any other delivery method that has been consented to by the party.

(b) "Party" means any recipient of a notice or document required as part of an insurance transaction. The term includes an applicant, an insured, a policyholder, and an annuity contract holder.

(2) Subject to subsection (4) of this section, any notice to a party or any other document required under applicable law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means if it meets the requirements of the "Uniform Electronic Transactions Act", article 71.3 of title 24, C.R.S.

(3) Delivery of a notice or document in accordance with this section is equivalent to any delivery method required under applicable law, including delivery by first-class mail; first-class mail, postage prepaid; certified mail; certificate of mail; or certificate of mailing.

(4) A notice or document may be delivered by electronic means by an insurer to a party under this section if:

(a) The party has affirmatively consented to that method of delivery and has not withdrawn the consent;

(b) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of:

(I) Any right or option of the party to have the notice or document provided or made available in paper or another nonelectronic form;

(II) The right of the party to withdraw consent to have a notice or document delivered by electronic means and any conditions or consequences imposed if the consent is withdrawn;

(III) Whether the party's consent applies:

(A) Only to the particular transaction as to which the notice or document must be given; or

(B) To identified categories of notices or documents that may be delivered by electronic means during the course of the party's relationship with the insurer;

(IV) The means, after consent is given, by which the party may obtain a paper copy of a notice or document delivered by electronic means; and

(V) The procedure a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update information needed to contact the party electronically;

(c) The party:

(I) Before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(II) Consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means as to which the party has given consent; and

(d) If, after the party consents, a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies, the insurer:

(I) Provides the party with a statement of:

(A) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(B) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed under subparagraph (II) of paragraph (b) of this subsection (4); and

(II) Provides the party with a complete and updated version of the information listed in paragraph (b) of this subsection (4).

(5) This section does not affect any requirement related to the content or timing of a notice or other document required under applicable law.

(6) If a provision of this title or other applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(7) The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party shall not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with subparagraph (II) of paragraph (c) of subsection (4) of this section.

(8) (a) A withdrawal of consent by a party:

(I) Does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective; and

(II) Is effective within a reasonable period of time after receipt of the withdrawal by the insurer.

(b) An insurer's failure to comply with paragraph (d) of subsection (4) of this section may be treated, at the election of the party, as a withdrawal of consent for purposes of this section.

(9) This section does not apply to a notice or document delivered by electronic means before August 6, 2014, to a party who, before that date, had consented to receive notice or documents in an electronic form otherwise allowed by law.

(10) If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before August 6, 2014, and the insurer intends to deliver additional notices or documents to such party in an electronic form pursuant to this section, then,

before delivering the additional notices or documents by electronic means, the insurer shall notify the party of:

(a) Any notices or documents that may be delivered by electronic means under this section that were not previously delivered electronically; and

(b) The party's right to withdraw consent to have notices or documents delivered by electronic means.

(11) (a) Except as otherwise provided by law, if an oral communication or a recording of an oral communication from a party can be reliably stored and reproduced by an insurer, the oral communication or recording qualifies as a notice or document delivered by electronic means for purposes of this section.

(b) If a provision of this title or other applicable law requires a signature or notice or document to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if the electronic signature of the person authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the signature, notice, or document.

(12) (a) This section shall not be construed to modify, limit, or supersede the provisions of the federal "Electronic Signatures in Global and National Commerce Act", Pub.L. 106-229, as amended.

(b) In the event of any conflict between this section and the "Uniform Electronic Transactions Act", article 71.3 of title 24, C.R.S., this section controls.

Source: L. 2014: Entire section added, (HB 14-1344), ch. 207, p. 762, § 1, effective August 6.

10-1-138. Internet posting of standard insurance provisions - conditions - notice of revisions. (1) Notwithstanding any provision of section 10-1-137 to the contrary, standard insurance policies and endorsements that do not contain personally identifiable information may be mailed, delivered, or posted on the insurer's website. If the insurer elects to post insurance policies and endorsements on its website in lieu of mailing or delivering them to the insured, it shall comply with all of the following conditions:

(a) The policies and endorsements must be accessible on the website and remain so for as long as the policies are in force.

(b) The policies and endorsements must be posted in a manner that enables the insured to print and save the policies and endorsements using programs or applications that are widely available on the internet and free to use.

(c) The insurer shall provide the following information in, or simultaneously with, each declarations page provided at the time of issuance of the initial policy and any renewals of that policy:

(I) A description of the exact policy and endorsement forms purchased by the insured;

(II) A method by which the insured may obtain, upon request and without charge, a paper or electronic copy of each policy and endorsement purchased by the insured; and

(III) The internet address where the insured's policies and endorsements are posted.

(d) The insurer shall archive its expired policies and endorsements for at least five years and make them available upon request.

(e) The insurer shall provide the insured with notice, in the same manner in which the insurer customarily communicates with the insured, of:

(I) Any changes to the forms or endorsements;

(II) The insured's right to obtain, upon request and without charge, a paper copy of the forms or endorsements; and

(III) The internet address where the forms or endorsements are posted.

Source: L. 2014: Entire section added, (HB 14-1344), ch. 207, p. 762, § 1, effective August 6.

10-1-139. Confidentiality. (1) Except as otherwise provided by law, when the commissioner conducts an investigation, all documents, including working papers, claim files, recorded information, electronic mail, and all copies of those documents, that are produced or obtained by or disclosed to the commissioner or any other person in the course of the investigation shall be treated as confidential until the commissioner concludes the investigation. After an investigation is concluded, the records are subject to the "Colorado Open Records Act", part 2 of article 72 of title 24.

(2) This section does not apply to an examination conducted pursuant to part 2 of this article 1 or to a market conduct surveillance conducted pursuant to part 3 of this article 1.

Source: L. 2017: Entire section added, (HB 17-1231), ch. 284, p. 1552, § 1, effective January 1, 2018.

10-1-140. Subpoena authority. The division may issue subpoenas, administer oaths, and examine under oath any person as to any matter relevant to the regulatory authority of the division. Upon the failure or refusal of a person to obey a subpoena, the division may petition a court of competent jurisdiction for an order, which order is enforceable through contempt proceedings, compelling the person to appear and testify or produce documentary evidence. The commissioner may arrange for the services of an administrative law judge appointed pursuant to part 10 of article 30 of title 24 to take evidence and to make findings and report them to the commissioner.

Source: L. 2017: Entire section added, (HB 17-1231), ch. 284, p. 1552, § 1, effective January 1, 2018.

10-1-141. Investigations - rules. (1) The commissioner may contract, pursuant to section 24-50-504 (2)(c) and (2)(e), with a person that has technical or subject matter expertise or skill and experience in investigative techniques to assist the division in performing investigations of a company or producer pursuant to this title 10 when the commissioner determines that the division lacks sufficient technical expertise to perform the investigation. Investigations conducted pursuant to this section do not include market conduct surveillance actions conducted pursuant to part 3 of this article 1. The commissioner shall, by rule, establish when contract investigators may be used for investigations. The rules must include out-of-state travel requirements, criteria for when special expertise is required for the investigation, and a

requirement that there must be a significant pattern of complaints or a well-documented allegation against a company for an investigation to be warranted.

(2) The investigated company or producer shall pay the reasonable fees and expenses of a person retained or designated for investigations of the company or producer pursuant to subsection (1) of this section directly to the retained or designated person, as determined by the commissioner. The investigated company or producer may contest the amount of fees and expenses charged by the retained or designated person by filing an objection with the commissioner, setting forth the charges that the investigated company or producer considers to be unreasonable and the basis for the claim that the charges are unreasonable. A disputed amount is not due unless the commissioner reviews the objection and makes a written finding that the disputed charges were reasonable in relation to the investigation performed.

Source: L. 2017: Entire section added, (HB 17-1231), ch. 284, p. 1553, § 1, effective January 1, 2018.

10-1-142. Prohibition on denial of coverage or increase in premiums of insurance for living organ donors - commissioner to enforce - short title - definitions. (1) The short title of this section is the "Living Donor Protection Act of 2019".

(2) Notwithstanding any other law, a person subject to regulation by the division pursuant to this title 10 shall not:

(a) Decline or limit coverage of a person under a policy or contract for life insurance, disability income insurance, health insurance, or long-term care insurance due to the status of the person as a living organ donor;

(b) Preclude a person from donating all or part of an organ as a condition of receiving a policy or contract for life insurance, disability income insurance, health insurance, or long-term care insurance;

(c) Consider the status of a person as a living organ donor in determining the premium rate for coverage of the person under a policy or contract for life insurance, disability income insurance, health insurance, or long-term care insurance; or

(d) Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price, or any other condition of a policy or contract for life insurance, disability income insurance, health insurance, or long-term care insurance for a person based solely and without any additional actuarial risks upon the status of the person as a living organ donor.

(3) The commissioner may use any of the commissioner's enforcement powers to obtain a person's compliance with this section.

(4) (a) The division shall provide information to the public on the access of a living organ donor to insurance as specified in this section. If the division receives materials related to live organ donation from a recognized live organ donation organization, the division shall make the materials available to the public.

(b) If the department of public health and environment receives materials related to live organ donation from a recognized live organ donation organization, the department of public health and environment shall make the materials available to the public.

(c) The division and the department of public health and environment may seek and accept gifts, grants, or donations from private or public sources for the purposes of this subsection (4).

(5) As used in this section:

(a) "Disability income insurance" means a contract under which an entity promises to pay a person a sum of money in the event that an illness or injury resulting in a disability prevents the person from working.

(b) "Health insurance" means a health benefit plan as defined in section 10-16-102 (32).

(c) "Life insurance" has the same meaning as set forth in section 10-7-301.5 (5).

(d) "Living organ donor" means a living person who has donated all or part of an organ.

(e) "Long-term care insurance" has the same meaning as set forth in section 10-19-103 (5).

Source: L. 2019: Entire section added, (HB 19-1253), ch. 367, p. 3368, § 1, effective August 2.

10-1-143. Study on homeowner's insurance - repeal. (Repealed)

Source: L. 2022: Entire section added, (SB 22-206), ch. 173, p. 1156, § 5, effective May 17.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 2023. (See L. 2022, p. 1156.)

10-1-144. Cost to reconstruct a home - annual report - homeowner's insurance affordability study - rules. (1) (a) The commissioner shall contract with an independent third party to prepare an annual residential reconstruction consumer information report on the cost of reconstructing homes in Colorado, taking into account the region of the state, the home types by design structure, different home customization types, and the factors included in section 10-4-110.8 (8). The commissioner shall complete the report by April 1, 2025, and by April 1 of each year thereafter based on data from the preceding calendar year.

(b) The division shall post the annual report prepared pursuant to this subsection (1) on the division's website by April 15 of each year.

(2) After a stakeholder process, the commissioner may contract with an independent third party to evaluate policies to address the affordability of homeowner's insurance.

(3) The commissioner may promulgate rules to implement this section.

Source: L. 2023: Entire section added, (HB 23-1174), ch. 168, p. 819, § 1, effective August 7.

10-1-145. Study regarding standards for the remediation of residential premises after fire - required considerations - report - repeal. (1) (a) The division shall conduct or cause to be conducted a study that:

(I) Evaluates methods of inspecting, testing, and remediating residential premises that have been damaged by smoke, soot, ash, and other contaminants as a result of a fire;

(II) Includes recommendations regarding the establishment of uniform standards for the inspection, testing, and remediation of residential premises that have been damaged by smoke, soot, ash, and other contaminants as a result of a fire; and

(III) Considers the extent to which any recommended uniform standards related to the remediation of residential premises damaged by fire, including damage from smoke, soot, ash, and other contaminants, impact the cost and availability of homeowners insurance.

(b) The division may contract with a third party to conduct all or part of the study.

(2) The study conducted pursuant to this section must consider:

(a) Existing practices and methods for the cleaning, repair, and remediation of residential premises, structures, personal property, and home furnishings that have been damaged by smoke, soot, ash, and other contaminants as a result of a fire;

(b) Existing standards, if any, for the testing, inspection, and remediation of residential premises, structures, home furnishings, and personal property that have been damaged by smoke, soot, ash, and other contaminants as a result of a fire, including any relevant standards established by the Institute of Inspection Cleaning and Restoration Certification or a successor entity;

(c) Guidelines for determining whether structures, home furnishings, and personal property can be remediated after experiencing damage from smoke, soot, ash, and other contaminants to levels that are protective of health and safety;

(d) Existing indoor air quality health and safety standards, if available, regarding the habitability of residential premises, specifically after those residential premises have been damaged by smoke, soot, ash, and other contaminants as a result of a fire, including, to the extent practicable, indoor air quality health and safety standards for individuals who are more susceptible to health issues due to exposure to smoke, soot, ash, and other contaminants; and

(e) The extent to which typical homeowners insurance policies cover damages to residential premises that are the result of a fire, including damage from smoke, soot, ash, and other contaminants, and the extent to which those insurance policies effectively cover the cost of the cleaning, repair, and remediation of the residential premises.

(3) The division, or a third party the division contracts with, shall engage with relevant stakeholders in conducting the study pursuant to subsections (1) and (2) of this section. Relevant stakeholders may include:

(a) Representatives from the department of public health and environment;

(b) Individuals who own homes or other residential premises;

(c) Representatives from the homeowners insurance industry in Colorado;

(d) Public health experts;

(e) Representatives from the industrial hygienist industry in Colorado;

(f) Representatives from the residential remediation and restoration industry in Colorado; and

(g) Representatives from organizations that advocate for the interests of consumers of homeowners insurance policies.

(4) On or before January 1, 2026, the division shall submit a report to the house of representatives health and human services committee and the senate local government and housing committee, or their successor committees. The report must include the research, findings, and recommendations of the study conducted in accordance with subsections (1) and (2) of this section.

(5) This section is repealed, effective December 31, 2027.

Source: L. 2024: Entire section added, (HB 24-1315), ch. 417, p. 2852, § 2, effective August 7.

Cross references: For the legislative declaration in HB 24-1315, see section 1 of chapter 417, Session Laws of Colorado 2024.

PART 2

EXAMINATIONS

10-1-201. Legislative declaration. The general assembly finds, determines, and declares that it is necessary to establish an effective and efficient system for examining the activities, operations, financial conditions, and affairs of all persons transacting the business of insurance in this state and all persons otherwise subject to the jurisdiction of the commissioner. The provisions of this part 2 are intended to enable the commissioner to adopt a flexible system of examinations that directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance-related laws of this state.

Source: L. 2003: Entire article RC&RE, p. 605, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-201 as it existed prior to 2002.

10-1-202. Definitions. As used in this part 2, unless the context otherwise requires:

(1) "Company" means any person or group of persons engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to any administrative, regulatory, or taxing authority of the commissioner as well as any advisory organization or rating organization as defined in section 10-4-402.

(2) "Examination" means a formal financial examination, as well as informal examinations, conducted by the commissioner for the purpose of determining compliance with the law.

(3) "Examiner" means any individual or firm authorized by the commissioner to conduct an examination under this part 2.

(4) "Informal examination" means all inquiries by the division into the financial condition of a company, other than the formal financial examination of a company that must be conducted once every five years pursuant to section 10-1-203 (1).

(5) "Insurance department" means the commissioner or other government official or agency of a state other than Colorado exercising powers and duties substantially equivalent to those of the commissioner or the division.

(6) "Insurer" means any person, firm, corporation, association, or aggregation of persons doing an insurance business and subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization, or conservation by, the commissioner or any equivalent insurance supervisory official of another state.

(7) "NAIC" or "national association of insurance commissioners" means the organization of insurance regulators from the fifty states, the District of Columbia, and the five United States territories.

(8) "Person" means any individual, aggregation of individuals, trust, association, partnership, or corporation, or any agent or affiliate thereof.

Source: L. 2003: Entire article RC&RE, p. 605, § 1, effective July 1. **L. 2006:** (1.5), (1.7), and (8) to (19) added and (7) amended, p. 960, § 3, effective January 1, 2007. **L. 2017:** Entire section amended, (HB 17-1231), ch. 284, p. 1553, § 2, effective January 1, 2018. **L. 2023:** (7) amended, (HB 23-1301), ch. 303, p. 1816, § 5, effective August 7.

Editor's note: This section is similar to former § 10-1-202 as it existed prior to 2002.

Cross references: For the legislative declaration contained in the 2006 act enacting subsections (1.5), (1.7), and (8) to (19) and amending subsection (7), see section 1 of chapter 211, Session Laws of Colorado 2006.

10-1-203. Authority, scope, and scheduling of examinations. (1) The commissioner or the commissioner's designee may conduct an examination of any company as often as the commissioner, in the commissioner's sole discretion, deems appropriate but shall, at a minimum, conduct a formal financial examination of every insurer licensed in this state not less frequently than once every five years; except that this does not include eligible nonadmitted insurers regulated in accordance with article 5 of this title 10. In scheduling financial examinations and in determining their nature, scope, and frequency, the commissioner shall consider matters such as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the most recent available edition of the examiners' handbook adopted by the national association of insurance commissioners.

(2) For purposes of completing an examination of any company under this part 2, the commissioner may examine or investigate any person or the business of any person insofar as such examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company.

(3) In lieu of a financial examination under this part 2 of any foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state; except that such reports may only be accepted if:

(a) The insurance department was, at the time of the examination, accredited under the national association of insurance commissioners' financial regulation standards and accreditation program; or

(b) The examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by the examiners' insurance department.

Source: L. 2003: Entire article RC&RE, p. 606, § 1, effective July 1. **L. 2012:** (1) amended, (HB 12-1215), ch. 104, p. 354, § 7, effective August 8. **L. 2017:** (1) amended, (HB 17-1231), ch. 284, p. 1555, § 3, effective January 1, 2018.

Editor's note: This section is similar to former § 10-1-203 as it existed prior to 2002.

10-1-204. Conduct of examinations - conferences - penalty. (1) (a) In conducting the examination, the examiners shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the national association of insurance commissioners and the Colorado insurance examiners handbook. The commissioner may also employ other guidelines or procedures as the commissioner deems appropriate.

(b) Repealed.

(2) (a) Every company or person from whom information is sought and all officers, directors, and agents of the company or person shall provide to the examiners timely, convenient, and free access at reasonable hours at its offices to all books, records, accounts, papers, tapes, computer records, and other documents relating to the property, assets, business, and affairs of the company being examined. The company or person shall make the books, records, and documents available for examination or inspection at the office location of the division when the commissioner determines that it is reasonably cost-effective to do so. The officers, directors, employees, and agents of the company or person shall facilitate the examination and aid in the examination to the extent it is in their power to do so.

(b) (I) The refusal of any company or any of its officers, directors, employees, or agents to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension, revocation, denial, or nonrenewal of any license or authority held by the company and subject to the commissioner's jurisdiction.

(II) Proceedings for any suspension or revocation pursuant to this subsection (2) shall be conducted in accordance with section 10-1-110.

(3) Repealed.

(4) Any person who knowingly or willfully testifies falsely in reference to any matter material to an examination or inquiry commits a class 2 misdemeanor.

(5) Any person who knowingly or willfully makes any false certificate, entry, or memorandum upon any of the books or papers of a company or upon any statement filed or offered to be filed in the division or used in the course of any examination or inquiry, with the intent to deceive the commissioner or any person appointed by the commissioner to conduct or make the examination or inquiry, commits a class 2 misdemeanor.

(6) (a) In addition to any other powers granted to the commissioner in this section or in any other provision of law, the commissioner may require any company, entity, or new applicant to be examined by independent examiners certified by the society of financial examiners or the insurance regulatory examiners society, actuaries who are members of the American academy of actuaries, or by any other qualified and competent loss reserve specialists, independent risk managers, independent certified public accountants, auditors, other examiners of insurance companies, or combination of such persons. Any domestic company may make a request to the commissioner to be so examined.

(b) (I) The commissioner may accept, as part of an examination, reports made by any person qualified and competent to conduct the examination as set forth in this subsection (6); except that neither the person, nor any member of the person's immediate family, may be:

(A) An officer of, connected with, or financially interested in the company, entity, or applicant being examined, other than as a policyholder; or

(B) Financially interested in any other corporation or person affected by the examination or by any related investigation or hearing.

(II) A person that conducts an examination pursuant to this subsection (6) shall keep strictly confidential all information, regardless of its source, obtained through any examination or about any examinee and shall disclose the information only to the commissioner or the examinee upon the specific request of either. The commissioner shall establish guidelines for assuring the neutrality of those persons to be authorized to supplement the examination procedures authorized in this section.

(III) The examinee shall pay the reasonable expenses and charges of a person retained or designated pursuant to this subsection (6) directly to the person. The examinee may contest the amount of fees, costs, and expenses charged by the person by filing an objection with the commissioner, setting forth the charges that the examinee considers to be unreasonable and the basis for the claim that the charges are unreasonable. A disputed amount is not due to the examiner unless the commissioner reviews the objection and makes a written finding that the disputed charges were reasonable in relation to the examination performed.

(7) Nothing contained in this part 2 shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(8) Nothing contained in this part 2 shall be construed to limit the commissioner's authority to use and, if appropriate, to make public, if consistent with section 10-3-414, any final or preliminary examination report, any examiner or company work papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action that the commissioner may, in the commissioner's sole discretion, deem appropriate.

(9) (a) For examinations of foreign companies made outside the borders of this state and of executive or branch offices of domestic companies located outside the borders of this state, the examined company shall pay the costs of the examination, including the expenses of the commissioner and the commissioner's assistants, who must be paid the same compensation as other examiners on such examinations.

(b) and (c) Repealed.

(d) When insurance companies not authorized to do business in this state, companies adjudged insolvent, or companies for any cause withdrawing from this state neglect, fail, or refuse to pay the reasonable charges for examination as approved by the commissioner, such charges shall be paid by the state treasurer from the general fund upon the order of the commissioner, and the amount so paid shall be a first lien upon all assets and property of such company and may be recovered by suit by the attorney general on behalf of the state of Colorado and restored to the general fund.

(10) and (11) Repealed.

Source: L. 2003: Entire article RC&RE, p. 607, § 1, effective July 1. **L. 2014:** (11) added, (SB 14-210), ch. 267, p. 1068, § 1, effective August 6. **L. 2017:** (1)(a), (2)(a), (4), (5), (6)(b), and (9)(a) amended and (1)(b), (3), (9)(b), (9)(c), (10), and (11) repealed, (HB 17-1231), ch. 284, p. 1556, § 4, effective January 1, 2018. **L. 2021:** (4) and (5) amended, (SB 21-271), ch. 462, p. 3146, § 108, effective March 1, 2022.

Editor's note: This section is similar to former § 10-1-204 as it existed prior to 2002.

Cross references: For the penalty for a class 2 misdemeanor, see § 18-1.3-501.

10-1-205. Financial examination reports. (1) Examination reports must comprise only facts appearing upon the books, records, or other documents of the company, its agents, or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and the conclusions and recommendations as the examiners find reasonably warranted based upon the facts.

(2) No later than sixty days after completion of the examination, the examiner in charge shall file with the division a verified written report of examination under oath. Upon receipt of the verified report, the division shall transmit to the company examined both the report and a notice stating that the company examined shall be afforded a reasonable period not exceeding thirty days, within which to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) Within thirty days after the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, any written submissions or rebuttals, and any relevant portions of the examiner's work papers and shall enter an order that does one or more of the following:

(a) Adopts the examination report as filed or with specified modifications or corrections; and if the examination report reveals that the company is operating in violation of any law, rule, or prior lawful order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violation; or

(b) Rejects the examination report and directs the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information and to refile the report pursuant to subsection (1) of this section; or

(c) Calls for an investigatory hearing, upon no less than twenty days' notice to the company, for purposes of obtaining additional documentation, data, information, and testimony; or

(d) May impose a monetary penalty of not more than three thousand dollars for every act in violation of any law, rule, or prior lawful order of the commissioner described in the report of examination, but not to exceed an aggregate penalty of thirty thousand dollars unless the company knew or reasonably should have known that its conduct was in violation of any law, rule, or prior lawful order of the commissioner, in which case the penalty shall not be more than thirty thousand dollars for every act or violation, but not to exceed an aggregate penalty of seven hundred fifty thousand dollars annually.

(4) (a) All orders entered pursuant to subsection (3)(a) of this section must be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner work papers, and any written submissions or

rebuttals. The order is a final agency decision and must be served upon the company by certified mail together with a copy of the adopted examination report. Notwithstanding the requirements of section 10-1-127, the final agency decision is subject to judicial review by the district court pursuant to section 24-4-106.Within thirty days after issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that the directors have received a copy of the adopted report and related orders.

(b) Any hearing conducted under paragraph (c) of subsection (3) of this section by the commissioner or an authorized representative shall be conducted as a nonadversarial, confidential, investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant work papers or by the written submission or rebuttal of the company. Such hearing shall not be subject to the "State Administrative Procedure Act", article 4 of title 24, C.R.S. Within twenty days after the conclusion of any such hearing, the commissioner shall enter an order pursuant to paragraph (a) of subsection (3) of this section.

(c) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to the examiner's work papers that tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation, whether under the control of the division, the company, or other persons. The documents produced shall be included in the record. Testimony taken by the commissioner or representative shall be under oath and preserved for the record.

(d) The hearing shall proceed with the commissioner or representative posing questions to the persons subpoenaed. Thereafter, the company and the division may present testimony relevant to the investigation. The company and the division shall be permitted to make closing statements and may be represented by counsel of their choice.

(e) Any order issued by the commissioner pursuant to subsection (3)(d) of this section may be appealed to the district court.

(5) Upon the adoption of the examination report pursuant to paragraph (a) of subsection (3) of this section, the commissioner shall continue, for at least thirty days, to hold the content of the examination report as private and confidential information except to the extent provided in subsection (2) of this section. Thereafter, the commissioner may open the report for public inspection unless a court of competent jurisdiction has stayed its publication.

(6) No provision of this title shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto to the insurance division of this or any other state or country, or to law enforcement officials of this or any other state, or to any agency of the federal government at any time subject to the written agreement of the recipient to hold such information confidential and to treat it in a manner consistent with this part 2.

(7) In the event the commissioner determines that regulatory action is appropriate as a result of any examination, the commissioner may initiate any proceedings or actions as provided by law.

(8) **Confidentiality of ancillary information.** (a) All working papers, recorded information, documents, and copies thereof that are produced or obtained by or disclosed to the

commissioner or any other person in the course of an examination made under this part 2 or in the course of analysis of the financial condition of the company by the commissioner are confidential, are not subject to subpoena, and may not be made public by the commissioner or any other person except to the extent provided in subsection (5) of this section; except that the commissioner may grant the NAIC access to the materials. Disclosure of the materials may be made only upon the prior written agreement of the recipient to hold the information confidential as required by this section or upon the prior written consent of the company to which it pertains.

(b) Neither the commissioner nor any person who received the documents, materials, or other information while acting under the authority of the commissioner, including the NAIC and its affiliates and subsidiaries, may testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (8)(a) of this section.

Source: L. 2003: Entire article RC&RE, p. 610, § 1, effective July 1. **L. 2004:** IP(3) amended, p. 1058, § 2, effective July 1. **L. 2008:** (3)(d) amended, p. 2171, § 1, effective August 5. **L. 2017:** (1), (4)(a), (4)(e), and (8) amended, (HB 17-1231), ch. 284, p. 1558, § 5, effective January 1, 2018.

Editor's note: This section is similar to former § 10-1-205 as it existed prior to 2002.

10-1-206. Conflict of interest. (1) No examiner may be appointed by the commissioner if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this part 2; except that this section shall not be construed to automatically preclude an examiner from being:

(a) A policyholder or claimant under an insurance policy;

(b) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(c) An investment owner in shares of regulated diversified investment companies; or

(d) A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

(2) Notwithstanding any provision of this section to the contrary, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions even though such persons may from time to time be similarly employed or retained by persons subject to examination under this part 2.

Source: L. 2003: Entire article RC&RE, p. 612, § 1, effective July 1.

Editor's note: This section is similar to former § 10-1-206 as it existed prior to 2002.

10-1-207. Immunity from liability - prohibited activity. (1) No cause of action shall arise, nor shall any liability be imposed, against the commissioner, the commissioner's authorized representatives, or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this part 2.

(2) No cause of action shall arise, nor shall any liability be imposed, against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this part 2, if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(3) This section does not abrogate or modify in any way any common-law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (1) of this section.

(4) A person identified in subsection (1) of this section shall be entitled to an award of attorney fees and costs if such person is the prevailing party in a civil action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this part 2 and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(5) An insurer shall not take any retaliatory personnel action against an employee because the employee provides information to or testifies before the commissioner conducting an examination into the practices of the company.

(6) (a) An employee who has been the subject of a retaliatory personnel action in violation of subsection (5) of this section may institute a civil action in a court of competent jurisdiction for relief within one year after the date of the alleged retaliatory action.

(b) A court of competent jurisdiction may order relief as follows:

(I) Reinstatement of the employee to the same position held before the retaliatory personnel action or an equivalent position;

(II) Reinstatement of full benefits and seniority rights; and

(III) Compensation for lost wages and benefits.

(c) Upon a determination that an insurer has taken a retaliatory personnel action, the court may award costs of the action together with reasonable attorney fees.

Source: L. 2003: Entire article RC&RE, p. 613, § 1, effective July 1. **L. 2006:** (5) and (6) added, p. 971, § 5, effective January 1, 2007. **L. 2017:** (5) amended, (HB 17-1231), ch. 284, p. 1560, § 6, effective January 1, 2018.

Editor's note: This section is similar to former § 10-1-207 as it existed prior to 2002.

Cross references: For the legislative declaration contained in the 2006 act enacting subsections (5) and (6), see section 1 of chapter 211, Session Laws of Colorado 2006.

10-1-208. Informal investigations. (Repealed)

Source: L. 2004: Entire section added, p. 72, § 1, effective March 8. **L. 2017:** Entire section repealed, (HB 17-1231), ch. 284, p. 1560, § 7, effective January 1, 2018.

10-1-209. Short title. (Repealed)

Source: L. 2006: Entire section added, p. 962, § 4, effective January 1, 2007. **L. 2017:** Entire section repealed, (HB 17-1231), ch. 284, p. 1560, § 7, effective January 1, 2018.

10-1-210. Market analysis procedures. (Repealed)

Source: L. 2006: Entire section added, p. 962, § 4, effective January 1, 2007. **L. 2017:** Entire section repealed, (HB 17-1231), ch. 284, p. 1560, § 7, effective January 1, 2018.

10-1-211. Protocols for market conduct actions. (Repealed)

Source: L. 2006: Entire section added, p. 964, § 4, effective January 1, 2007. **L. 2012:** (6) added, (HB 12-1266), ch. 280, p. 1494, § 7, effective July 1. **L. 2013:** (6) amended, (HB 13-1236), ch. 202, p. 840, § 5, effective May 11. **L. 2017:** Entire section repealed, (HB 17-1231), ch. 284, p. 1560, § 7, effective January 1, 2018.

10-1-212. Targeted, on-site market conduct examinations - rules. (Repealed)

Source: L. 2006: Entire section added, p. 965, § 4, effective January 1, 2007. **L. 2017:** Entire section repealed, (HB 17-1231), ch. 284, p. 1560, § 7, effective January 1, 2018.

10-1-213. Confidentiality requirements. (Repealed)

Source: L. 2006: Entire section added, p. 968, § 4, effective January 1, 2007. **L. 2010:** (5) added, (HB 10-1220), ch. 197, p. 852, § 8, effective July 1. **L. 2017:** Entire section repealed, (HB 17-1231), ch. 284, p. 1560, § 7, effective January 1, 2018.

10-1-214. Market conduct surveillance personnel. (Repealed)

Source: L. 2006: Entire section added, p. 970, § 4, effective January 1, 2007. **L. 2017:** Entire section repealed, (HB 17-1231), ch. 284, p. 1560, § 7, effective January 1, 2018.

10-1-215. Fines and penalties. (Repealed)

Source: L. 2006: Entire section added, p. 970, § 4, effective January 1, 2007. **L. 2017:** Entire section repealed, (HB 17-1231), ch. 284, p. 1560, § 7, effective January 1, 2018.

10-1-216. Participation in national market conduct databases. (Repealed)

Source: L. 2006: Entire section added, p. 970, § 4, effective January 1, 2007. **L. 2017:** Entire section repealed, (HB 17-1231), ch. 284, p. 1560, § 7, effective January 1, 2018.

10-1-217. Coordination with other states through NAIC. The commissioner shall share information and coordinate the division's examination efforts with other states through the NAIC.

Source: L. 2006: Entire section added, p. 971, § 4, effective January 1, 2007. **L. 2017:** Entire section amended, (HB 17-1231), ch. 284, p. 1560, § 8, effective January 1, 2018.

Cross references: For the legislative declaration contained in the 2006 act enacting this section, see section 1 of chapter 211, Session Laws of Colorado 2006.

10-1-218. Additional duties of commissioner.

(1) Repealed.

(2) (a) The commissioner shall designate a specific person or persons within the division whose responsibilities shall include the receipt of information from employees of insurers and licensed entities concerning violations of laws or rules by insurers. The designated person or persons shall be provided with proper training on the handling of the information, including procedures to maintain the confidentiality of the communication for purposes of this section.

(b) The information received pursuant to this subsection (2) is a confidential communication and is not public information.

Source: L. 2006: Entire section added, p. 971, § 4, effective January 1, 2007. **L. 2017:** (1) repealed, (HB 17-1231), ch. 284, p. 1560, § 9, effective January 1, 2018.

Cross references: For the legislative declaration contained in the 2006 act enacting this section, see section 1 of chapter 211, Session Laws of Colorado 2006.

PART 3

MARKET CONDUCT

10-1-301. Legislative declaration. The general assembly finds, determines, and declares that it is necessary to establish an effective and efficient system for reviewing, evaluating, and analyzing the activities, operations, and affairs of all persons transacting the business of insurance in this state and all persons otherwise subject to the jurisdiction of the commissioner. This part 3 is intended to enable the commissioner to adopt a flexible system of review, evaluation, and analysis that directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance-related laws of this state.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1560, § 10, effective January 1, 2018.

10-1-302. Definitions. As used in this part 3, unless the context otherwise requires:

(1) "Commissioner" means the commissioner of insurance, the commissioner's deputies, or the division of insurance.

(2) "Company" means any person or group of persons engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business or any person or group of persons who may otherwise be subject to any administrative, regulatory, or taxing authority of the commissioner, as well as any advisory organization or rating organization as defined in section 10-4-402.

(3) "Complaint" means any written communication, or oral communication that is subsequently converted to a written form, that expresses a grievance or dissatisfaction with a specific person or entity subject to regulation by the division.

(4) "Division" means the division of insurance, the commissioner of insurance, or a government official or agency of a state other than Colorado exercising powers and duties substantially equivalent to those of the commissioner or the division.

(5) "Market analysis" means a process whereby market conduct surveillance personnel collect and analyze information from filed schedules, surveys, required reports, and other sources in order to develop a baseline understanding of the marketplace and to identify patterns or practices of companies that deviate from the norm or that may pose risk to the insurance consumer.

(6) "Market conduct examination" includes any type of examination as set forth in the Market Regulation Handbook that assesses a company's compliance with the laws, rules, and regulations applicable to the company. Market conduct examinations include desk examinations, on-site examinations, follow up examinations, and targeted examinations.

(7) "Market conduct surveillance" means any of the full range of activities that the commissioner may initiate to assess and address the market practices of any company licensed or registered pursuant to this title 10 to conduct business in this state, including market analysis, interrogatories, and market conduct examinations.

(8) "Market conduct surveillance personnel" means those individuals employed by or under contract with the commissioner to collect, analyze, review, or act on information about the insurance marketplace that identifies patterns or practices of companies.

(9) "Market Regulation Handbook" means the guidelines developed and issued by the NAIC that are designed to be used to conduct uniform, standardized market conduct surveillance.

(10) "NAIC" or "national association of insurance commissioners" means the organization of insurance regulators from the fifty states, the District of Columbia, and the five United States territories.

(11) "Person" means any individual, aggregation of individuals, trust, association, partnership, or corporation, or any agent or affiliate thereof.

(12) "Standard data request" means the set of field names and descriptions developed and adopted by the NAIC for use by market conduct surveillance personnel in an examination.

(13) "Third-party model or product" means a model or product provided by an entity separate from and not under direct or indirect corporate control of the company using the model or product.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1561, § 10, effective January 1, 2018. **L. 2023:** (10) amended, (HB 23-1301), ch. 303, p. 1816, § 6, effective August 7.

10-1-303. Market analysis - market conduct surveillance. (1) The commissioner may perform market analysis by gathering and analyzing information from data currently available to the commissioner, information from surveys, data calls, or reports that are submitted regularly to the commissioner, information collected by the NAIC, and information from a variety of other sources in both the public and private sectors in order to develop a baseline understanding of the

marketplace and to identify for further review companies or practices that deviate from the norm or that may pose a potential risk to the insurance consumer. The commissioner shall use the Market Regulation Handbook as a guide in performing the market analysis.

(2) (a) If the commissioner determines that further inquiry into a particular company or practice is needed, the commissioner may consider the continuum of other types of market conduct surveillance as specified in this subsection (2)(a). The commissioner shall inform the company in writing of the type of market conduct surveillance selected if it involves company participation or response. The types of market conduct surveillance include:

(I) Correspondence with the company;

(II) Company interviews;

(III) Information gathering;

(IV) Policy and procedure reviews;

(V) Interrogatories;

(VI) Review of company self-evaluations and voluntary compliance programs;

(VII) Self-audits; and

(VIII) Market conduct examinations.

(b) (I) The commissioner shall take steps reasonably necessary to eliminate requests for information that duplicate information provided as part of a company's financial statement, the NAIC's market conduct annual statement, or other required surveys, data calls, or reports that are submitted regularly to the commissioner.

(II) The commissioner may coordinate the market conduct surveillance and findings of this state with market conduct surveillance and findings of other states.

(3) Nothing in this section requires the commissioner to conduct market analysis prior to initiating any other type of market conduct surveillance.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1562, § 10, effective January 1, 2018.

10-1-304. Authority and scope of market conduct surveillance - rules - penalty. (1) The commissioner may conduct market conduct surveillance of any company as often as the commissioner, in the commissioner's sole discretion, deems appropriate. When initiating market conduct surveillance and in determining its nature, scope, and frequency, the commissioner may consider any market analysis performed pursuant to section 10-1-303 and any other criteria as set forth in the most recent available edition of the Market Regulation Handbook.

(2) For purposes of completing market conduct surveillance of any company under this part 3, the commissioner may review, evaluate, or analyze any person or the business of any person to the extent the action is, in the sole discretion of the commissioner, necessary or material to the market conduct surveillance.

(3) In conducting market conduct surveillance, market conduct surveillance personnel shall consider those guidelines and procedures set forth in the most recent available edition of the Market Regulation Handbook. The commissioner may also employ other standard insurance industry guidelines or procedures the commissioner deems appropriate.

(4) Any person who knowingly or willfully testifies falsely in reference to any matter material to any market conduct surveillance, or who knowingly or willfully makes any false certificate, entry, or memorandum upon any of the books or papers of a company or upon any

statement filed or offered to be filed with the commissioner or used in the course of any market conduct surveillance or inquiry commits a class 2 misdemeanor.

(5) (a) Every company or person from whom information is sought and all officers, directors, and agents of the company or person shall provide to the market conduct surveillance personnel timely, convenient, and free access to all books, records, accounts, papers, tapes, computer records, and other documents relating to the property, assets, business, and affairs of the company. The officers, directors, employees, and agents of the company or person shall facilitate the market conduct surveillance and aid in the review, evaluation, or analysis to the extent it is in their power to do so.

(b) (I) The refusal of any company or any of its officers, directors, employees, or agents to submit to any type of market conduct surveillance or to comply with any reasonable written request of market conduct surveillance personnel is grounds for suspension, revocation, denial, or nonrenewal of any license or authority held by the company and subject to the commissioner's jurisdiction.

(II) Proceedings for any suspension or revocation pursuant to this subsection (5)(b) must be conducted in accordance with section 10-1-110.

(6) (a) The company subject to market conduct surveillance shall pay the reasonable fees and expenses of the market conduct surveillance.

(b) (I) The commissioner or the commissioner's assistants shall conduct market conduct surveillance of a domestic company unless the commissioner determines that good cause exists to have the market conduct surveillance conducted by contract market conduct surveillance personnel.

(II) The commissioner shall adopt rules for determining when contract market conduct surveillance personnel may be used and the reasonable fees and expenses that the company subject to the market conduct surveillance shall pay. The rules must include factors such as travel requirements, workload needs, special expertise required for the market conduct surveillance, and market issues requiring any unanticipated market conduct surveillance.

(c) When an insurance company not authorized to do business in this state, a company adjudged insolvent, or a company withdrawing from this state for any cause neglects, fails, or refuses to pay the reasonable fees and expenses for market conduct surveillance as approved by the commissioner:

(I) The state treasurer shall pay the fees and expenses from the general fund upon the order of the commissioner; and

(II) The amount paid is a first lien upon all assets and property of the company and may be recovered by suit filed by the attorney general on behalf of the state of Colorado and credited to the general fund.

(7) Nothing in this part 3 limits the commissioner's authority to terminate or suspend any market conduct surveillance in order to pursue other legal or regulatory action pursuant to the insurance laws of this state.

(8) (a) Where the reasonable and necessary cost of any type of market conduct surveillance is to be assessed against the company subject to the market conduct surveillance, the fee must be consistent with the Market Regulation Handbook. The fees and expenses must be itemized and must include receipts for all applicable expenses, and invoices shall be provided to the division on at least a monthly basis for review prior to submission to the company for

payment. The company subject to the market conduct surveillance shall pay fees and expenses at least monthly.

(b) The commissioner shall maintain active management and oversight of costs, including costs associated with the commissioner's own market conduct surveillance personnel and with retaining qualified contract market conduct surveillance personnel. To the extent the commissioner retains outside assistance, the commissioner shall have written protocols that:

(I) Establish and utilize a dispute resolution or arbitration mechanism to resolve conflicts with companies regarding fees and expenses; and

(II) Require disclosure of the terms of the contracts with the outside consultants that will be used, including the fees and hourly rates that may be charged.

(c) A company cannot be required to reimburse any portion of fees under this subsection (8) incurred by market conduct surveillance personnel that exceeds the fees prescribed in the Market Regulation Handbook and any successor documents to that handbook, unless the commissioner demonstrates that the fees prescribed in the Market Regulation Handbook are inadequate under the circumstances of the type of market conduct surveillance conducted.

(d) A company may request an independent audit of the fees and expenses charged within twelve months after the completion of any type of market conduct surveillance. The company is responsible for the cost of the independent audit. Market conduct surveillance personnel shall maintain documentation supporting the fees and expenses charged to the company for at least twelve months after the completion of the market conduct surveillance.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1563, § 10, effective January 1, 2018. **L. 2021:** (4) amended, (SB 21-271), ch. 462, p. 3146, § 109, effective March 1, 2022.

Cross references: For the penalty for a class 2 misdemeanor, see § 18-1.3-501.

10-1-305. Market conduct examinations. (1) The commissioner may conduct a market conduct examination of any company as often as the commissioner, in the commissioner's sole discretion, deems appropriate; except that the commissioner shall rely upon the state of domicile to conduct market conduct examinations of those eligible nonadmitted insurers regulated in accordance with article 5 of this title 10.

(2) To the extent practicable, the commissioner shall coordinate a market conduct examination of a foreign company authorized under this title 10 to do business in this state with the insurance commissioner of the company's state of domicile.

(3) (a) Except when extraordinary circumstances indicating a risk to consumers requires immediate action, at least sixty days before starting a market conduct examination, the division shall notify the company that a market conduct examination will be performed.

(b) The division shall use the standard data request or a successor or modified product that is substantially similar to the standard data request.

(c) At the same time the notice is sent to the company, the division shall provide notice on the NAIC's examination tracking system or successor NAIC product that a market conduct examination has been scheduled.

(4) (a) Except when extraordinary circumstances indicating a risk to consumers requires immediate action, at least thirty days before starting the market conduct examination, the

division shall offer, in writing, to conduct a preexamination conference with the company's examination coordinator and key personnel to discuss:

(I) Early resolution and simplification of procedures;

(II) Avoidance of the production of unnecessary or duplicative information; and

(III) Facilitation of complete, accurate, just, speedy, and inexpensive disposition of the examination.

(b) Except when extraordinary circumstances indicating a risk to consumers requires immediate action, at least thirty days before starting the market conduct examination, the division shall prepare and provide to the company subject to the examination a work plan consisting of the following:

(I) The name and address of the company being examined;

(II) The name and contact information of the market conduct surveillance personnel who will be conducting the examination;

(III) The type of market conduct examination being conducted;

(IV) The scope of the examination;

(V) The date the examination is scheduled to begin;

(VI) A time estimate for the duration of the examination; and

(VII) An estimated cost for the examination.

(c) If a market conduct examination is expanded beyond the scope provided to the company in the work plan, the division shall:

(I) Provide written notice to the company explaining the extent of and reasons for the expansion; and

(II) Provide the company with a revised work plan as soon as practicable.

(5) Before concluding a market conduct examination, the division shall offer, in writing, to hold a predraft conference with the company subject to the examination at least thirty days before filing a draft report. If the company chooses to have a predraft conference, the division shall design and conduct the predraft conference in accordance with the examination report provisions of the Market Regulation Handbook to facilitate:

(a) Resolution of outstanding issues;

(b) Discussion of possible corrective actions;

(c) Review of the examination report before it is filed in draft form; and

(d) Complete, accurate, just, speedy, and inexpensive conclusion of the examination.

(6) (a) The division shall adhere to the following procedure or timeline, unless a mutual agreement is reached with the company to modify the procedure or timeline:

(I) The division shall deliver the draft report to the company within sixty days after completion of the market conduct examination, which is the date when the division confirms in writing that the examination is completed.

(II) The company may respond with written submissions or rebuttals challenging any issue contained in the draft report within thirty days after the date of the draft report. Any issue in the draft report that is not challenged by the company is deemed accepted by the company. The company's written submissions and rebuttals must be included in the market conduct surveillance personnel's work papers.

(III) Unless a mutual agreement is reached to extend the deadline, within thirty days after the period allowed for the company's written submissions or rebuttals ends, the division shall provide to the company a final report. The division shall not include any issues in the final

report that were not included in the draft report without providing the company an opportunity to supplement its submissions and rebuttals in order to respond to any new issue. The company must file any supplement to its submissions and rebuttals within fourteen days after the division issues the final report.

(IV) Within thirty days after issuance of the final report, the company must accept the findings of the final report or request a written hearing.

(b) If the company accepts the findings of the final report, the following procedures apply:

(I) The commissioner shall issue an order adopting the final report as written or with specified modifications or corrections within thirty days after the company accepts the report.

(II) (A) The commissioner shall include with an order issued pursuant to subsection (6)(b)(I) of this section findings and conclusions resulting from the commissioner's consideration and review of the final report, relevant market conduct surveillance personnel work papers, and any written submissions or rebuttals.

(B) An order issued pursuant to subsection (6)(b)(I) of this section is a final agency action and shall be served upon the company by certified mail together with a copy of the adopted final report. Within sixty days after issuance of the adopted final report, the company shall file affidavits executed by each of its directors stating under oath that the directors have received a copy of the final report and related orders.

(III) Notwithstanding the requirements of section 10-1-127, if the final agency order modifies or corrects the final report accepted by the company, the company may appeal the modified or corrected portions of the final agency order, including the penalty or all or part of any fine or civil penalty imposed in the order, to the district court pursuant to section 24-4-106. In the absence of any modification or corrections to the final report accepted by the company, the company does not have a right to judicial review of the final agency action adopted by the commissioner except for the right to appeal the penalty or all or part of any fine or civil penalty imposed in the order to the district court pursuant to section 24-4-106.

(c) If the company requests a written hearing, the following procedures apply:

(I) The company must request the written hearing in writing and must specify the issues in the final report that the company is challenging. The company is limited to challenging the issues that were previously challenged in the company's written submission and rebuttal or supplemental submission and rebuttal as provided pursuant to subsections (6)(a)(II) and (6)(a)(III) of this section.

(II) The hearing shall be conducted by written arguments submitted to the commissioner.

(III) Discovery is limited to the market conduct surveillance personnel's work papers that are relevant to the issues the company is challenging. The relevant market conduct surveillance personnel's work papers are deemed admitted and included in the record. No other forms of discovery, including depositions and interrogatories, are allowed, except upon the written agreement of the company and the division.

(IV) Only the company and the division may submit written arguments.

(V) The company must submit its written argument within thirty days after it requests the hearing.

(VI) The division shall submit its written response within thirty days after the end of the period allowed for the company to submit its written argument.

(VII) The commissioner shall issue a decision accompanied by findings and conclusions resulting from the commissioner's consideration and review of the written arguments, the final report, relevant market conduct surveillance personnel work papers, and any written submissions or rebuttals. The commissioner's order is a final agency action and shall be served upon the company by certified mail together with a copy of the final report. Unless the effective date of the final agency order is postponed pursuant to section 24-4-106 (5), within sixty days after issuance of the final agency order, the company shall file affidavits executed by each of its directors stating under oath that the directors have received a copy of the final report and related orders.

(VIII) Any portion of the final report that is not or cannot be challenged by the company is incorporated into the decision of the commissioner.

(IX) Notwithstanding the requirements of section 10-1-127, the commissioner's decision is a final agency action appealable to the district court pursuant to section 24-4-106.

(7) Findings of fact and conclusions of law in the commissioner's final agency action are prima facie evidence in any legal or regulatory action.

(8) (a) The commissioner shall continue to hold the content of any final agency action of a market conduct examination as private and confidential for a period of forty-nine days after the final agency action. After the forty-nine-day period expires, the commissioner shall open the final agency action for public inspection if a court of competent jurisdiction has not stayed its publication.

(b) Nothing in this part 3 prevents the commissioner from disclosing the content of an examination report, preliminary examination report, or results, or any matter relating to a report or results, to the division or to the insurance division of any other state or agency or office of the federal government at any time if the division, agency, or office receiving the report or related matters agrees and has the legal authority to hold it confidential in a manner consistent with this part 3.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1565, § 10, effective January 1, 2018.

10-1-306. Market conduct surveillance personnel. (1) Market conduct surveillance personnel must be qualified by education, experience, and, where applicable, professional designations. The commissioner may supplement the in-house market conduct surveillance staff with qualified outside professional assistance if the commissioner determines that outside assistance is necessary.

(2) The commissioner shall not appoint market conduct surveillance personnel who, either directly or indirectly, have a conflict of interest or are affiliated with the management of or own a pecuniary interest in any person subject to any type of market conduct surveillance under this part 3; except that this section does not preclude market conduct surveillance personnel from being:

(a) A policyholder or claimant under an insurance policy;

(b) A grantor of a mortgage or similar instrument on the market conduct surveillance employee's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(c) An investment owner in shares of regulated diversified investment companies; or

(d) A settlor or beneficiary of a blind trust into which any otherwise impermissible holdings have been placed.

(3) Notwithstanding any provision of this section to the contrary, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or similar individuals who are independently practicing their professions even though those individuals may from time to time be similarly employed or retained by companies subject to market conduct surveillance under this part 3.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1569, § 10, effective January 1, 2018.

10-1-307. Immunity from liability - prohibited activity. (1) A cause of action does not arise, and liability shall not be imposed, against the commissioner, the commissioner's authorized representatives, or any market conduct surveillance personnel employed or appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this part 3.

(2) A cause of action does not arise, and liability shall not be imposed, against any person for communicating or delivering information or data to the commissioner, the commissioner's authorized representative, or any market conduct surveillance personnel pursuant to a market conduct surveillance performed under this part 3, if the communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(3) This section does not abrogate or modify any common-law or statutory privilege or immunity enjoyed by any person identified in subsection (1) of this section.

(4) A person identified in subsection (1) of this section is entitled to an award of attorney fees and costs if the person is the prevailing party in a civil action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this part 3, and the party bringing the action was not substantially justified in bringing the action. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(5) (a) A company shall not take any retaliatory personnel action against an employee because the employee provides information pursuant to any type of market conduct surveillance examining the practices of the company.

(b) An employee who has been the subject of a retaliatory personnel action in violation of subsection (5)(a) of this section may institute a civil action in a court of competent jurisdiction for relief within one year after learning of the alleged retaliatory action.

(c) A court of competent jurisdiction may order relief as follows:

(I) Reinstatement of the employee to the same position held before the retaliatory personnel action or to an equivalent position;

(II) Reinstatement of full benefits and seniority rights; and

(III) Compensation for lost wages and benefits.

(d) Upon a determination that a company has taken a retaliatory personnel action, the court may award costs of the action together with reasonable attorney fees.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1570, § 10, effective January 1, 2018.

10-1-308. Rules. In accordance with article 4 of title 24, the commissioner may promulgate reasonable rules that are necessary or proper for implementing and administering this part 3, including rules necessary to align state law with the requirements for accreditation set forth by the NAIC.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1571, § 10, effective January 1, 2018.

10-1-309. Confidentiality requirements. (1) (a) Market conduct surveillance personnel have free and full access to the following documents of and persons associated with the company during regular business hours:

(I) Books;

(II) Records, including any self-evaluation or voluntary compliance program documents;

(III) Employees;

(IV) Officers; and

(V) Directors.

(b) Upon request of market conduct surveillance personnel, a company utilizing a third-party model or product for any of the activities being reviewed shall make the details of the models or products available to the personnel.

(c) (I) The commissioner and any other person in the course of market conduct surveillance shall keep confidential all documents, including working papers, third-party models or products, complaint logs, and copies of any documents created, produced, obtained by, or disclosed to the commissioner, market conduct surveillance personnel, or any other person in the course of market conduct surveillance conducted pursuant to this part 3, and all documents obtained by the NAIC as a result of this part 3. The documents remain confidential beyond the termination of the market conduct surveillance, are not subject to subpoena, and must not be made public at any time or used by the commissioner or any other person, except as provided in subsections (2), (3), and (5) of this section and section 10-1-312.

(II) The commissioner, the division, and any other person in the course of market conduct surveillance shall keep confidential any self-evaluation or voluntary compliance program documents disclosed to the commissioner or other person by a company and the data collected via the NAIC market conduct annual statement. The documents are not subject to subpoena and shall not be made public or used by the commissioner or any other person, except as provided in subsections (2), (3), and (5) of this section and section 10-1-312.

(2) Notwithstanding subsection (1) of this section, and consistent with subsection (3) of this section, in order to assist in the performance of the commissioner's duties, the commissioner may:

(a) Share documents, materials, communications, or other information, including the confidential and privileged documents, materials, or information specified in subsection (1) of this section, with other state, federal, and international regulatory agencies and law enforcement authorities and the NAIC, its affiliates, and subsidiaries, if the recipient agrees to and has the legal authority to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(b) Receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its

affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, communication, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, communication, or information; and

(c) Enter into agreements governing the sharing and use of information consistent with this section.

(3) Nothing in this part 3 limits:

(a) The commissioner's authority to use, if consistent with section 10-3-414, any final or preliminary examination report, any market conduct surveillance or company work papers or other documents, or any other information discovered or developed during the course of any market conduct surveillance, in the furtherance of any legal or regulatory action initiated by the commissioner that the commissioner may, in the commissioner's sole discretion, deem appropriate; or

(b) The ability of a company to conduct discovery in accordance with section 10-1-305 (6)(c)(III).

(4) Disclosure to the commissioner of documents, materials, communications, or information required as part of any type of market conduct surveillance does not waive any applicable privilege or claim of confidentiality in the documents, materials, communications, or information.

(5) Notwithstanding the confidentiality requirements in subsection (1)(c) of this section, when the commissioner performs any type of market conduct surveillance that does not rise to the level of a market conduct examination, the commissioner may make the final results of the market conduct surveillance, in an aggregated format, available for public inspection in a manner deemed appropriate by the commissioner.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1571, § 10, effective January 1, 2018.

10-1-310. Fines and penalties. (1) As a result of any market conduct surveillance, the commissioner may order a monetary penalty of up to three thousand dollars for every act in violation of any law, rule, or prior lawful order of the commissioner, not to exceed an aggregate penalty of thirty thousand dollars for every act or violation. If the company knew or reasonably should have known that its conduct was in violation of any law, rule, or prior lawful order of the commissioner, the commissioner may order a penalty of up to thirty thousand dollars for every act or violation, not to exceed an aggregate penalty of two hundred thousand dollars in any one calendar year.

(2) The commissioner shall ensure that fines and penalties levied as a result of market conduct surveillance or other action enforcing this part 3 are consistent, reasonable, and justified. Every fine or penalty must relate to the general business practices and compliance activities of insurers and not to clearly infrequent or unintentional random errors that do not cause significant consumer harm.

(3) When determining the appropriate civil penalty for a company and whether to stay any portion of the civil penalty, the commissioner shall consider:

(a) Actions taken by the company to maintain membership in, and comply with the standards of, best-practice organizations that promote high ethical standards of conduct in the marketplace;

(b) The extent to which the company maintains regulatory compliance programs to self-assess, self-report, and remediate problems detected; and

(c) Regulatory compliance programs or corrective actions that a company has instituted voluntarily prior to or during the pendency of any market conduct surveillance in order to remedy violations.

(4) If the commissioner stays any portion of the civil penalty, the commissioner may reinstate the full civil penalty, and may impose additional penalties, if the company fails to remedy the violations.

(5) The commissioner shall include in the final agency order the civil penalty amount per violation for every act in violation of any law, rule, or prior lawful order of the commissioner.

Source: L. 2017: (2) amended, (SB 17-249), ch. 283, p. 1544, § 4, effective September 1; entire part added, (HB 17-1231), ch. 284, p. 1573, § 10, effective January 1, 2018.

10-1-311. Participation in national market conduct databases. (1) The commissioner shall report market data to the NAIC's market information systems, including the complaint database system, the examination tracking system, and the regulatory information retrieval system, or other successor NAIC products as determined by the commissioner.

(2) (a) The commissioner shall report complaints to the NAIC complaint database system, or its successor product, in accordance with NAIC guidelines. However, before publication of company-specific complaint information by the commissioner, insurance industry personnel shall be given the opportunity to review Colorado-specific complaints assigned to their company in the commissioner's complaints database and request that corrections be made to the data. The commissioner shall review company objections to assigned complaints before publishing company-specific complaints information and shall make corrections to the commissioner's complaints database when appropriate. If the commissioner makes corrections to its complaints database based on errors identified by a company, the commissioner shall send corrected data to the NAIC complaint database system, or its successor product.

(b) The commissioner shall ensure that companies have until at least February 15 to review complaints data for the immediately preceding calendar year. In order for a company's objections to its complaints data information to be considered, the company must review and request any corrections to the prior calendar year's complaints data no later than February 15.

(3) Information maintained by the commissioner shall be compiled in a manner that meets the requirements of the NAIC.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1574, § 10, effective January 1, 2018.

10-1-312. Coordination with other states through NAIC. (1) The commissioner may share information and coordinate the commissioner's market surveillance efforts with other states through the NAIC.

(2) Consistent with section 10-1-309, in order to assist in the performance of the commissioner's duties, the commissioner may:

(a) Share documents, materials, communications, or other information, including the confidential and privileged documents, materials, or information subject to section 10-1-309 (1), with other state, federal, and international regulatory agencies and law enforcement authorities and the NAIC, its affiliates, and subsidiaries, if the recipient agrees to and has the legal authority to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(b) Receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, communication, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, communication, or information; and

(c) Enter into agreements governing the sharing and use of information consistent with this section.

Source: L. 2017: Entire part added, (HB 17-1231), ch. 284, p. 1574, § 10, effective January 1, 2018.

LICENSES

ARTICLE 2

Licenses

Editor's note: (1) This article was numbered as articles 1 and 32 of chapter 72, C.R.S. 1963. Part 2 of this article was repealed and reenacted in 1977 and the substantive provisions of this article were repealed and reenacted in 1993, effective January 1, 1995, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this article prior to 1993, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers, prior to 1993, are shown in editor's notes following those sections that were relocated.

(2) The effective date and applicability for this article are contained in § 10-2-1101.

Cross references: For an alternative disciplinary action that may be imposed upon persons licensed pursuant to this article, see § 24-34-106.

PART 1

GENERAL PROVISIONS

10-2-101. Short title. This article shall be known and may be cited as the "Colorado Producer Licensing Model Act".

Source: L. 93: Entire article R&RE, p. 1348, § 1, effective January 1, 1995. **L. 2001:** Entire section amended, p. 1190, § 1, effective January 1, 2002.

10-2-102. Scope - applicability. This article governs the qualifications and procedures for the licensing of insurance producers. This article is intended to simplify and organize some statutory language to improve efficiency, permit the use of new technology, and reduce costs associated with issuing, continuing, and renewing insurance licenses.

Source: L. 93: Entire article R&RE, p. 1348, § 1, effective January 1, 1995. **L. 2001:** Entire section amended, p. 1190, § 2, effective January 1, 2002.

Editor's note: This section is similar to former § 10-2-201 as it existed prior to 1993.

10-2-103. Definitions. As used in this article, unless the context otherwise requires:

(1) "Catastrophic disaster" means an event, as declared by the president of the United States or the governor, or both, which results in large numbers of deaths or injuries; causes extensive damage or destruction of property or facilities that provide and sustain human needs; produces an overwhelming demand on state and local response resources and mechanisms; causes a severe long-term effect on general economic activity; or severely affects state, local, and private sector capabilities to begin and sustain response activities.

(1.5) "Commissioner" means the commissioner of insurance.

(2) "Health coverage" means accident and health or sickness and accident policies or contracts including other health coverages provided by insurers, health maintenance organizations, or nonprofit hospital and surgical plans.

(2.5) "Home state" means the District of Columbia and any state or territory of the United States in which an insurance producer meets the following:

(a) Maintains the producer's principal place of residence or principal place of business; and

(b) Is licensed to act as an insurance producer.

(3) "Individual" means any private or natural person as distinguished from a partnership, corporation, association, or any foreign or domestic entity as defined in section 7-90-102, C.R.S.

(4) "Insurance" means any of the lines of authority set forth in section 10-2-407 (1).

(5) "Insurance agency" or "business entity" means a corporation, partnership, association, or foreign or domestic entity as defined in section 7-90-102, C.R.S., or other legal entity that transacts the business of insurance.

(6) "Insurance producer" or "producer", except as otherwise provided in section 10-2-105, means:

(a) A person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

(I) Policies of insurance for risks residing, located, or to be performed in this state;

(II) Membership in a prepayment plan as defined in parts 2 and 3 of article 16 of this title; or

(III) Membership enrollment in a health-care plan as defined in part 4 of article 16 of this title; and

(b) A public adjuster.

(6.5) "Insurer" means every person engaged as principal, indemnitor, surety, or contractor in the business of making contracts of insurance.

(7) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the lines of authority, specified in such document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurance carrier to a binding agreement.

(7.1) "Limited line insurance" means those lines of authority other than those defined in section 10-2-407 (1)(a) to (1)(e) or any other line of insurance that the commissioner may deem necessary to recognize for the purpose of complying with section 10-2-502.

(7.3) "Limited line producer" means a person authorized by the commissioner to sell, solicit, or negotiate limited lines of insurance.

(7.5) "Limited lines credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing the insured credit obligation that the commissioner determines should be designated a form of limited line credit insurance.

(7.7) "Limited lines credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited lines credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(7.9) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, if the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers or acts as a public adjuster.

(8) "Person" includes any individual or a business entity.

(8.5) "Public adjuster" means any person who, for compensation or any other thing of value on behalf of the insured:

(a) Acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property or allied lines of the insured, on behalf of an insured in negotiating for, or effecting, the settlement of a claim for loss or damage covered by an insurance contract;

(b) Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first-party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property or allied lines; or

(c) Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property or allied lines for another person engaged in the business of adjusting losses or damages covered by an insurance policy for the insured.

(9) (Deleted by amendment, L. 2001, p. 1190, § 3, effective January 1, 2002.)

(10) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(11) "Solicit" means attempting to sell insurance, asking or urging a person to apply for a particular kind of insurance from a particular company, or asking or urging a person to use the services of, or services in connection with activities as, a public adjuster.

(12) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

(13) "Uniform business entity application" means the current version of the national association of insurance commissioners' uniform business entity application for resident and nonresident business entities.

(14) "Uniform application" means the current version of the national association of insurance commissioners' uniform application for resident and nonresident producer licensing.

Source: L. 93: Entire article R&RE, p. 1348, § 1, effective January 1, 1995. **L. 2001:** (2.5), (6.5), (7.1), (7.3), (7.5), (7.7), (7.9), (10), (11), (12), (13), and (14) added and (3), (4), (5), (7), (8), and (9) amended, p. 1190, § 3, effective January 1, 2002. **L. 2009:** (7.1), (7.3), (7.5), and (7.7) amended, (SB 09-292), ch. 369, p. 1940, § 10, effective August 5. **L. 2013:** (1), (6), (7.9), and (11) amended and (1.5) and (8.5) added, (HB 13-1062), ch. 61, p. 200, § 1, effective January 1, 2014.

Editor's note: This section is similar to former §§ 10-2-102 and 10-2-202 as they existed prior to 1993.

10-2-104. Authority of commissioner - rules. Pursuant to the provisions of article 4 of title 24, C.R.S., the commissioner may promulgate reasonable rules for the implementation and administration of the provisions of this article. The commissioner may contract with any party for the purpose of performing any ministerial duty required of the commissioner under this article. All reasonable charges and expenses of such contractors shall be paid directly to the contractors by licensees.

Source: L. 93: Entire article R&RE, p. 1349, § 1, effective January 1, 1995. **L. 2001:** Entire section amended, p. 1192, § 4, effective January 1, 2002.

Editor's note: This section is similar to former § 10-2-220 as it existed prior to 1993.

10-2-105. Insurance producer - exemptions from definition. (1) Nothing in this article shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(2) Notwithstanding section 10-2-103 (6), "insurance producer" does not include the following:

(a) Any person who is a regularly salaried officer, director, or employee of an insurance company or an insurance producer and who is engaged in the performance of usual or customary executive, administrative, or clerical duties which do not include the negotiation or solicitation of insurance, so long as the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this state;

(b) Any person who is a salaried employee in the office of an insurance producer or insurer and who devotes full time to clerical and administrative services, including the incidental taking of insurance applications and receipt of premiums in the office of such person's employer, so long as the person does not receive any commission on such applications and the person's compensation is not varied by the volume of applications or premiums taken or received;

(c) An officer, director, or employee whose activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance;

(c.3) An officer, director, or employee whose function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance;

(c.5) An officer, director, or employee who is acting in the capacity of a special agent or agency supervisor assisting insurance producers, where the officer's, director's, or employee's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance;

(c.7) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, or group or blanket accident and health insurance or for the purpose of enrolling individuals under plans, issuing certificates under plans, or otherwise assisting in administering plans or performs administrative services related to mass marketed property and casualty insurance, where no commission is paid to the person for the service;

(d) Employers, associations, or their officers, directors, or employees, or the trustees of any employee trust plan, to the extent that such employers, associations, officers, directors, employees, or trustees are engaged in the administration or operation of any program of employee benefits for their own employees or the employees of their subsidiaries or affiliates, which program involves the use of insurance issued by an insurer; except that such employers, associations, officers, directors, employees, or trustees shall not in any manner be compensated, directly or indirectly, by the company issuing the contracts;

(e) Employees of insurers or insurance agencies or organizations employed by insurers or insurance agencies who are engaging in the inspection, rating, or classification of risks or in the supervision of the training of insurance producers and who are not individually engaged in the solicitation or negotiation of policies or contracts for insurance;

(f) Management associations, partnerships, or corporations whose operations do not entail solicitation of insurance from the public;

(g) Officers or employees of a motor vehicle rental company that offers coverage in connection with and incidental to the rental of motor vehicles under motor vehicle rental agreements, so long as such coverage is:

(I) Offered at the point of the rental transaction or by preselection of coverage in master, corporate, group, or individual rental agreements;

(II) Limited in scope to the parties to such motor vehicle rental agreements and to other authorized drivers or occupants of the vehicles being rented;

(III) Limited in duration to coverage of damages incurred as a result of events occurring during the rental period; and

(IV) For traditionally recognized risks associated with motor vehicle operation and travel, including, without limitation, personal injury or death, personal liability and property

damage, collision, damage to or loss of personal effects, roadside assistance, and emergency repairs;

(h) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, so long as the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;

(i) A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance, for commercial property and casualty risks, to an insured with risks located in more than one state insured under that contract, so long as the person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(j) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, so long as the employee does not sell or solicit insurance or receive a commission.

(2.5) With respect to public adjusters, a license as a public adjuster is not required for:

(a) An attorney-at-law admitted to practice in this state, when acting in his or her professional capacity as an attorney;

(b) A person who negotiates or settles claims arising under a life or health insurance policy or an annuity contract;

(c) A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance of an incidental nature to a licensed public adjuster, including a photographer, estimator, private investigator, engineer, or handwriting expert;

(d) A licensed health-care provider, or employee of a licensed health-care provider, who prepares or files a health claim form on behalf of a patient; or

(e) A person who settles subrogation claims between insurers.

Source: L. 93: Entire article R&RE, p. 1350, § 1, effective January 1, 1995. **L. 98:** (1)(g) added, p. 234, § 3, effective April 10. **L. 2001:** Entire section amended, p. 1192, § 5, effective January 1, 2002. **L. 2013:** (2.5) added, (HB 13-1062), ch. 61, p. 201, § 2, effective January 1, 2014.

Editor's note: This section is similar to former § 10-2-209 as it existed prior to 1993.

Cross references: For the legislative declaration contained in the 1998 act enacting subsection (1)(g), see section 1 of chapter 88, Session Laws of Colorado 1998.

PART 2

PRELICENSURE EDUCATION

10-2-201. Prelicensure education - when required. (1) (a) Except as otherwise provided in section 10-2-202, in addition to other requirements for licensure as specified under this article and as a condition of initial licensure, an individual applicant for qualification in life,

sickness and accident, or property and casualty lines shall be required to provide evidence to the commissioner that the individual applicant has satisfactorily completed an approved prelicensure education or training course or program as follows:

(I) An individual seeking insurance producer licensure authority for life insurance shall complete at least fifty hours of an approved course or program for certification in life insurance; and, of the said fifty hours, at least three hours shall pertain specifically to insurance industry ethics;

(II) An individual seeking insurance producer licensure authority for health coverage shall complete at least fifty hours of an approved course or program for certification in sickness and accident insurance; and, of the said fifty hours, at least three hours shall pertain specifically to insurance industry ethics;

(III) An individual seeking insurance producer licensure authority for property or casualty insurance or both shall complete at least fifty hours of an approved course or program for certification in property or casualty insurance or both; and, of the said fifty hours, at least three hours shall pertain specifically to insurance industry ethics.

(b) An individual seeking an insurance producer license to include life, sickness and accident, property, or casualty lines or any combination thereof shall not be eligible to take the written examination provided for in section 10-2-402 until the prelicensure education requirements specified in this subsection (1) pertaining to the line or lines of insurance applied for have been satisfied.

(2) The commissioner shall adopt all rules necessary to carry out the prelicensing education provisions of this section. Such rules shall set forth standards for courses and programs to qualify for approval by the commissioner and shall also prescribe a system of control and reporting.

(3) An individual seeking an insurance producer license shall pay to the commissioner, in addition to any other applicable fees or charges, a fee established by the commissioner in accordance with section 10-2-413 for operation of the prelicensing education program.

Source: L. 93: Entire article R&RE, p. 1350, § 1, effective January 1, 1995.

10-2-202. Exemption from prelicensure education requirements. (1) Prelicensure education as set forth in section 10-2-201 shall not be required of an individual who is:

(a) Applying to reinstate a canceled or expired resident insurance producer license in this state when such license has been inactive for one year or less;

(b) Applying for temporary license authority under section 10-2-410;

(c) Applying for a resident insurance producer license in this state, was previously licensed in his or her former resident state, and has completed or satisfied prelicensure education as required by that state pertinent to the line or lines of insurance applied for in Colorado;

(d) Applying for a nonresident license in this state pertinent to the line or lines of authority held in the producer's home state.

Source: L. 93: Entire article R&RE, p. 1351, § 1, effective January 1, 1995. **L. 2001:** (1)(d) amended, p. 1194, § 6, effective January 1, 2002.

10-2-203. Course certification, registration, and review by commissioner. (1) Prelicensure education courses or programs that will be provided and offered to persons applying for life, sickness and accident, property, or casualty licensing are subject to review and certification by the commissioner, except that:

(a) Any full-time program of prelicensure education operated by a qualified domestic company or a company with a qualified home office located in Colorado shall not be subject to review and certification by the commissioner; and

(b) Any applicant or licensee who has attended such a course or program shall be deemed in compliance with the provisions of section 10-2-201 upon certification by the applicant that he or she has completed all required hours of instruction through such a course or program.

(2) Course instruction, content, outline, and course instructors are subject to initial approval by the commissioner and, at the discretion of the commissioner, are also subject to periodic review for continuation. The course provider shall remit the fee as prescribed in accordance with section 10-2-413 to continue or renew such approved course or program.

(3) If, upon review, the commissioner finds that a prelicensure education course or program is not in compliance with all applicable standards, as set forth by rule, the commissioner may order the course or program to be discontinued or revoke the approval of the course provider or both.

Source: L. 93: Entire article R&RE, p. 1352, § 1, effective January 1, 1995.

PART 3

CONTINUING EDUCATION

Cross references: For current provisions of the "Reinsurance Intermediary Act" previously located in this part 3, see part 9 of this article 2.

10-2-301. Continuing education requirement - rules. (1) Producers not exempt from the requirements of this section shall satisfactorily complete up to twenty-four hours of instruction by attending courses or programs of instruction approved by the commissioner. At least three of the twenty-four hours of continuing education must be for courses in ethics. For producers authorized to sell property or personal insurance lines of business, at least three of the twenty-four hours of continuing education must be for courses in homeowner's insurance coverage. The commissioner may adopt rules concerning testing requirements as a part of the certified continuing education. The producer shall complete the required hours of instruction within twenty-four months after the date the producer's license renews, beginning with renewal dates on or after January 1, 1993. A producer may accumulate no more than twelve carry-over credit hours during the one hundred twenty days before the licensing continuation date. Carry-over credits apply to the next continuing education period. If a producer has more than one license to sell insurance in this state, the producer shall complete the required hours of instruction within twenty-four months after the date of renewal of the first license. For good cause shown, the commissioner may grant an extension of time, not exceeding one additional year, within which to comply with this section. An instructor of an approved course of

instruction qualifies for the same number of hours of continuing education as a person attending and successfully completing the course or program, but an instructor shall not receive credit more than once for a course or program given more than once during the twenty-four-month period described in this subsection (1).

(2) Any producer who is subject to the requirements of this section shall furnish in a form satisfactory to the commissioner written proof of compliance with the requirements of this section. The requirements of this section are mandatory for any person specified in subsection (3)(a) of this section, and if any such person holds more than one license which is described in subsection (3) of this section, such person shall be required to complete the hours of instruction required under this section only once. For purposes of this section, the term "person" shall include any holder of a license to sell insurance under the laws of this state.

(3) (a) The requirements of this section shall apply to any resident person licensed to solicit and sell the following types of insurance in this state:

(I) Life insurance and annuity contracts, including variable life and annuity contracts;

(II) Sickness, accident and health insurance;

(III) Property and casualty insurance; and

(IV) Any other type of insurance for which the state requires an examination for licensure.

(b) This section shall not apply to any person holding a limited or restricted license if such license is in good standing with the division and no complaints have been filed against the licensee.

(3.5) (a) An individual who holds a public adjuster license and who is not exempt under paragraph (b) of this subsection (3.5) shall satisfactorily complete continuing education courses as required by the commissioner under this section.

(b) Licensees holding nonresident public adjuster licenses who have met the continuing education requirements of their home state and whose home state gives credit to residents of this state on the same basis meet the requirements of this section.

(4) Written certification of any course of instruction completed shall be executed by or on behalf of the sponsoring organization, in a form satisfactory to the commissioner.

(5) Any person who fails to comply with the requirements of this section, or is found after a hearing before the division to have submitted a false or fraudulent certificate of compliance to the commissioner, shall have his or her license suspended until such person satisfactorily demonstrates to the commissioner that all of the requirements of this section, and any other applicable licensing requirement or other statute, have been met.

(6) (a) The commissioner shall be responsible for administering the continuing insurance education requirements under this article and approving courses of instruction that qualify for such purposes. The commissioner shall promulgate such rules as the commissioner deems necessary to administer the continuing education requirements, including the provisions and requirements of this section. The commissioner shall also promulgate rules requiring that producers be required to provide to a continuing education administrator proof of compliance with the continuing education requirements as a condition of license renewal. For persons licensed pursuant to section 10-11-116 (1)(c), compliance with the continuing legal education credits requirements of the Colorado supreme court shall be deemed to meet the requirements of this section.

(b) The position of continuing education administrator shall be established by the commissioner either within the division of insurance or through a contractual arrangement with an outside service provider. All costs of such administrator shall be paid from continuing insurance education fees paid by producers in the manner provided by this section. In no event may the commissioner delegate course approval responsibilities to the continuing education administrator.

(c) Each producer licensed under this article is responsible for paying to the continuing education administrator a reasonable biennial fee for the operation of the continuing education programs, which fee is used to administer the provisions of this section.

(6.5) (a) Continuing education course instruction, content, outline, and course providers are subject to initial approval by the commissioner and, at the discretion of the commissioner, are subject to periodic review for continuation.

(b) If, upon review, the commissioner determines that a continuing education course or program is not in compliance with all applicable standards, as set forth by rule, the commissioner may order the course or program to be discontinued or revoke approval of the course provider, or both.

(7) Repealed.

Source: L. 93: Entire article R&RE, p. 1352, § 1, effective January 1, 1995. **L. 94:** (3)(b), (5), and (6)(b) amended, p. 1628, § 22, effective January 1, 1995. **L. 95:** (6.5) added, p. 89, § 1, effective March 30; (6)(a) and (6)(c) amended, p. 288, § 13, effective July 1. **L. 99:** (7) repealed, p. 104, § 1, effective March 24. **L. 2001:** (3) amended, p. 1195, § 7, effective January 1, 2002. **L. 2004:** (1) amended, p. 979, § 2, effective August 4. **L. 2012:** (6)(a) and (6)(c) amended, (HB 12-1266), ch. 280, p. 1494, § 8, effective July 1. **L. 2013:** (1) amended, (HB 13-1225), ch. 183, p. 676, § 4, effective January 1, 2014; (3.5) added, (HB 13-1062), ch. 61, p. 202, § 3, effective January 1, 2014.

Editor's note: This section is similar to former § 10-2-207.5 as it existed prior to 1993.

Cross references: In 2013, subsection (1) was amended by the "Homeowner's Insurance Reform Act of 2013". For the short title, see section 1 of chapter 183, Session Laws of Colorado 2013.

PART 4

LICENSING AND APPOINTMENT OF INSURANCE PRODUCERS

Cross references: For current provisions of the "Managing General Agents Act" previously located in this part 4, see part 10 of this article 2.

10-2-401. License required. (1) No person shall act as or hold oneself out to be an insurance producer unless duly licensed as an insurance producer in accordance with this article. Every insurance producer who solicits or negotiates an application for insurance of any kind on behalf of an insurer shall be regarded as representing the insurer and not the insured or any beneficiary of the insured in any controversy between the insurer and such insured or

beneficiary. A person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority in accordance with this article.

(2) No insurance producer shall make application for, procure, negotiate for, or place for others any policies for any line or lines of insurance for which he or she is not then qualified and licensed.

(3) (a) Any representative of a fraternal benefit society who solicits and negotiates insurance contracts is an insurance producer and is subject to the same licensing requirements as those for an insurance producer; except that a license is not required of any officer, employee, or secretary of a fraternal benefit society or of a subordinate lodge or branch thereof who devotes substantially all of his or her time to activities other than the solicitation or negotiation of insurance contracts and who receives no commission or other compensation directly dependent upon the number or amount of insurance contracts solicited or negotiated.

(b) Any agent, representative, or member of a fraternal benefit society who in the preceding calendar year solicited and procured life insurance contracts on behalf of any society in a face amount of insurance not exceeding fifty thousand dollars or, in the case of any other kind of insurance that the fraternal benefit society may write, solicited and procured such insurance on behalf of not more than twenty-five individuals, who received no commissions or other compensation therefor, and who does not reasonably expect to exceed soliciting or procuring insurance on behalf of more than twenty-five individuals in the current year, shall be exempt from the licensing requirements for an insurance producer.

(4) No insurance producer license shall be granted or extended to any person if the license is being or will be used for the purpose of writing controlled business. As used in this section, "controlled business" means insurance procured or to be procured by or through such person upon:

(a) The person's own life, person, property, or risks, or those of his or her spouse; or

(b) The life, person, property, or risks of the person's employer or the person's own business.

(5) Such a license shall be deemed to have been, or intended to be, used for the purpose of writing controlled business, if during any twelve-month period the aggregate amount of premiums on controlled business would exceed the aggregate amount of premiums on all other insurance business of the applicant or licensee.

(6) A title insurance agent and a title insurance company, as defined in section 10-11-102 (9) and (10), shall disclose the names of all affiliated business arrangements to which the company or agent is a party at the time of application for a new license, on the continuation due date of an existing license, and upon a change to any identifying information, in a form and manner acceptable to the commissioner. The disclosure shall include the physical location of the affiliated businesses, identify the settlement producer with whom the company or agent is associated, and identify the underwriter of the title insurance business.

Source: L. 93: Entire article R&RE, p. 1355, § 1, effective January 1, 1995. **L. 94:** (3) amended, p. 740, § 1, effective January 1, 1995. **L. 2001:** (1) amended, p. 1195, § 8, effective January 1, 2002. **L. 2006:** (6) added, p. 268, § 3, effective July 1.

Editor's note: This section is similar to former §§ 10-2-102 and 10-2-204 as they existed prior to 1993.

Cross references: For the provisions pertaining to fraternal benefit societies, see article 14 of this title 10.

10-2-402. License examination requirement. (1) Unless exempt pursuant to section 10-2-403, a resident individual applying for an insurance producer license shall pass a written examination. The examination shall reasonably test the individual applicant's minimum acceptable level of competence as to the particular line or lines of authority for which the individual applicant seeks qualification, unless an individual applicant has been licensed as an insurance producer for the same line or lines of authority in another state within the twelve months immediately preceding the date of receipt of application and files with the commissioner a letter of clearance, issued by the public official having supervision of insurance in the applicant's former state of residence, stating the individual held a license for the same line or lines of authority during such twelve-month period and that the license was in good standing.

(2) Examination for licensing shall be held at such reasonable times and places as are designated by the commissioner, and such times and places shall be made public.

(3) (a) Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the commissioner in accordance with section 10-2-413.

(b) The application for examination shall request the applicant to provide the following information:

(I) The applicant's name, age, residence address, business address, and mailing address;

(II) The name of any required prelicensing course he or she has completed or is in the process of completing;

(III) The method by which the applicant intends to qualify for the license if other than completing a prelicensing course;

(IV) The highest level of education achieved by the applicant; and

(V) The applicant's gender, native language, and race or ethnicity; except that the application shall contain a statement that an applicant is not required to disclose his or her gender, native language, or race or ethnicity, that he or she will not be penalized for not doing so, and that the department will use this information exclusively for research and statistical purposes and to improve the quality and fairness of the examinations.

(c) No later than six months after August 5, 2008, and annually thereafter, the commissioner shall prepare and publish a report that summarizes statistical information relating to insurance producer examinations administered during the preceding calendar year. The report shall include the following information for all examinees combined and separately by race or ethnicity, gender, race or ethnicity within gender, education level, and native language:

(I) The total number of examinees;

(II) The percentage and number of examinees who passed the examination;

(III) The mean scaled scores on the examination; and

(IV) Standard deviation of scaled scores on the examination.

(d) If the commissioner arranges to have the examinations for licensure administered by an independent testing service pursuant to section 10-2-402 (5), the commissioner may provide demographic information to the testing service if the commissioner requires the independent

examiner to review and analyze examination results in conjunction with the gender, native language, education level, and race or ethnicity of the examinees.

(4) (Deleted by amendment, L. 2001, p. 1195, § 9, effective January 1, 2002.)

(5) The commissioner shall give, conduct, and grade all examinations, or the commissioner may arrange to have examinations administered and graded by an independent testing service, as specified by contract, in a fair and impartial manner and without discrimination as to individuals examined. The commissioner may arrange for such testing service to recover the cost of the examination from the applicant.

(6) There shall be a separate portion of the examination required for each line of insurance which the applicant proposes to transact under the license.

(7) (Deleted by amendment, L. 2001, p. 1195, § 9, effective January 1, 2002.)

(8) An individual who fails to pass an examination shall remit the required fee and any forms required to retake the failed examination.

(9) An individual who fails to appear for a scheduled examination shall remit the required fee and any forms required to reapply to take the examination.

(10) Applicants for life, health coverages, property, or casualty examinations shall comply with prelicensure education requirements as prescribed in section 10-2-201 prior to taking the written examination.

(11) An insurance producer license issued on or before January 1, 2002, for health maintenance organizations ("HMO") or nonprofits may be renewed or continued until the licensee fails to meet the requirements of this part 4.

Source: L. 93: Entire article R&RE, p. 1356, § 1, effective January 1, 1995. **L. 97:** (5) amended, p. 1616, § 3, effective July 1. **L. 2001:** (1), (4), and (7) amended and (11) added, p. 1195, § 9, effective January 1, 2002. **L. 2008:** (11) amended, p. 209, § 2, effective March 26; (3) amended, p. 1515, § 1, effective August 5.

Editor's note: This section is similar to former §§ 10-2-106 and 10-2-207 as they existed prior to 1993.

10-2-403. Exemption from license examination. (1) The following applicants shall be exempt from the written examination requirements set forth in section 10-2-402:

(a) An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in this state or another state shall not be required to complete any prelicensing education or examination. This exemption is only available to a nonresident applicant if:

(I) (A) The person is currently licensed in his or her home state for the same line or lines of authority; or

(B) The application is received within twelve months after the cancellation of the applicant's previous license; and

(II) (A) The prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state; or

(B) The state's producer database records, maintained by the national association of insurance commissioners or its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(b) An individual applicant for a health maintenance organization or nonprofit hospital representative producer license or a travel-ticket-selling insurance producer license to solicit, procure, and deliver accident and health or travel baggage insurance policies offered by a life, casualty, or multiple-line insurer licensed in this state;

(b.5) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety days after establishing legal residence to become a resident licensee pursuant to section 10-2-404. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the insurance commissioner determines otherwise by regulation.

(c) An individual applicant who holds the designation of chartered life underwriter ("CLU"); except that such individual is not exempt from that portion of the examination pertaining to Colorado laws and rules pertinent to life insurance and health coverage insurance;

(d) An individual applicant who has attained the designation of chartered property and casualty underwriter ("CPCU"); except that such individual is not exempt from taking that portion of the examination pertaining to Colorado laws and rules pertaining to property, casualty, or health coverage;

(e) A nonresident individual applicant who is in compliance with section 10-2-501 (1)(a);

(f) A licensed life insurance producer applicant for a variable contracts license who is in compliance with the qualification requirement in section 10-2-407;

(g) An individual applicant who holds the designation of chartered financial consultant ("ChFC"); except that such individual is not exempt from that portion of the examination pertaining to Colorado laws and rules pertinent to life insurance and health coverage insurance;

(h) An individual applicant who holds the designation of registered health underwriter ("RHU"); except that such individual is not exempt from that portion of the examination pertaining to Colorado laws and rules pertinent to life insurance and health coverage insurance.

Source: L. 93: Entire article R&RE, p. 1357, § 1, effective January 1, 1995. **L. 95:** (1)(c) amended, p. 90, § 3, effective March 30. **L. 2001:** (1)(a) and (1)(f) amended and (1)(b.5), (1)(g), and (1)(h) added, p. 1196, § 10, effective January 1, 2002. **L. 2003:** IP(1) amended, p. 1982, § 6, effective May 22.

Editor's note: This section is similar to former § 10-2-211 as it existed prior to 1993.

10-2-404. Application for license. (1) An applicant for a resident insurance producer license shall make application on a form specified by the commissioner and shall declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall verify that:

(a) The individual is at least eighteen years of age;

(b) The individual has not committed any act which is a ground for denial, suspension, or revocation as set forth in section 10-2-801;

(c) The individual is a resident of this state or is a resident of another state and meets the requirements of section 10-2-502;

(d) If the individual applicant is a nonresident, such applicant has furnished the commissioner with a current certification of license status pursuant to section 10-2-502 (1)(e);

(e) Unless exempt, the individual has satisfied minimum prelicensure education requirements pursuant to part 2 of this article;

(f) The individual has paid the license fee prescribed by the commissioner in accordance with section 10-2-413;

(g) The individual has successfully passed the examination or has satisfied examination qualification requirements for the line or lines of authority for which the individual has applied; and

(h) The individual is competent, trustworthy, and of good moral character and good business reputation.

(2) An insurance agency or business entity acting as an insurance producer shall obtain an insurance producer license. Application shall be made on a form specified by the commissioner. Before approving the application, the commissioner shall verify that:

(a) The agency has disclosed to the insurance commissioner all officers, partners, and directors, whether or not they are licensed as insurance producers;

(b) The agency's officers, directors, or partners are trustworthy, of good moral character, and of good business reputation;

(c) The insurance agency or business entity has paid the fees prescribed by the commissioner in accordance with section 10-2-413;

(d) The insurance agency or business entity has designated a licensed producer who is an officer, partner, or director responsible for the insurance agency's or business entity's compliance with the insurance laws and rules of this state;

(e) The insurance agency or business entity has registered with the commissioner the name of each natural person who, as an officer, director, partner, owner, or member of the insurance agency or business entity, is acting as and is licensed as an insurance producer;

(f) The insurance agency or business entity has registered with the commissioner at least one individual who holds a valid insurance producer license for the line or lines of authority requested in the application;

(g) If the insurance agency's or business entity's filing status is nonresident, the insurance agency or business entity has complied with the qualification requirements of section 10-2-502.

(3) The commissioner may require the filing of any documents reasonably necessary to verify the information contained or required in the application.

(4) Each insurer that sells, solicits, or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting, or negotiating limited lines credit insurance, a program of instruction that may be approved by the insurance commissioner.

Source: L. 93: Entire article R&RE, p. 1357, § 1, effective January 1, 1995. **L. 2001:** IP(1), (1)(c), (1)(d), (1)(g), IP(2), (2)(c), (2)(d), (2)(e), (2)(f), and (2)(g) amended and (4) added, p. 1197, § 11, effective January 1, 2002.

Editor's note: This section is similar to former §§ 10-2-103 and 10-2-207 as they existed prior to 1993.

10-2-405. Residency - individuals - agencies. (1) The commissioner may qualify an applicant as a resident of this state and shall issue an insurance producer license to any qualified resident person of this state in accordance with the following:

(a) An individual applicant may qualify as a resident only if he or she resides in this state. Any license issued pursuant to any application claiming residency for licensing purposes shall constitute an election of residency in this state and shall be void if the licensee, while holding a resident license in this state, also holds or makes application for a license in or thereafter claims to be a resident of any other state or jurisdiction, or if the licensee ceases to be a resident of this state.

(b) An insurance agency or business entity may qualify as a resident if the agency has its principal office in this state;

(c) The resident person is in compliance with the requirements of section 10-2-404.

Source: L. 93: Entire article R&RE, p. 1359, § 1, effective January 1, 1995. **L. 2001:** (1)(b) amended, p. 1198, § 12, effective January 1, 2002.

Editor's note: This section is similar to former § 10-2-207 as it existed prior to 1993.

10-2-406. Licensing of agencies. (1) For the purposes set forth in section 10-2-701, an insurance agency or business entity shall be licensed as an insurance producer.

(2) (a) The insurance agency or business entity shall register the name of every natural person who, as a member, officer, director, stockholder, owner, or employee of the agency or business entity, is acting as and is licensed as an insurance producer.

(b) A fee, prescribed by the commissioner in accordance with section 10-2-413, shall be paid for the registration of each insurance producer.

(3) The insurance agency or business entity shall, within ten days, notify the commissioner, on a form prescribed by the commissioner, of every change relative to the licensed individual insurance producers registered and authorized to act as insurance producers for the insurance agency or business entity.

(4) The insurance agency or business entity shall, within ten days, notify the commissioner, on a form prescribed by the commissioner, of any change relative to the insurance agency or business entity name, officers, directors, partners, or owners, to report a merger, or that the insurance agency or business entity has ceased doing business in this state.

(5) When an insurance agency or business entity ceases to do business in this state, the insurance agency or business entity shall return the producer license to the commissioner within ten days after ceasing to do business.

(6) When an insurance agency or business entity changes its principal address to another state, the insurance agency or business entity shall, within ten days, notify the commissioner and return the producer license for cancellation. Relicensing will be subject to the provisions of part 5 of this article.

(7) (a) The insurance agency or business entity shall comply with section 10-2-404.

(b) A nonresident insurance agency shall also comply with the qualification requirements of section 10-2-501.

Source: L. 93: Entire article R&RE, p. 1359, § 1, effective January 1, 1995. **L. 2001:** (1), (2)(a), (3), (4), (5), (6), and (7)(a) amended, p. 1198, § 13, effective January 1, 2002.

10-2-407. License - definitions of lines of insurance - authority. (1) Unless a person is denied licensure pursuant to section 10-2-801, the division shall issue to a person who has met the requirements of sections 10-2-401 and 10-2-404 an insurance producer license. An insurance producer may receive qualification for a single license to include one or more of the following lines of authority:

(a) "Life", which means insurance coverage on human lives that:

(I) Shall include benefits of endowment and annuities; and

(II) May include benefits for:

(A) The event of death or dismemberment by accident; and

(B) Disability income;

(b) "Accident and health", which means insurance coverage for sickness, bodily injury, or accidental death and that may include benefits for disability income;

(c) "Variable life and variable annuity products", which means insurance coverage provided under variable life insurance contracts and variable annuities;

(d) "Property", which means insurance coverage for the direct or consequential loss or damage to property of every kind;

(e) "Casualty", which means insurance coverage against legal liability, including that for death, injury, or disability or damage to real or personal property;

(f) Repealed.

(g) Limited lines credit insurance;

(h) Crop hail;

(i) Title;

(j) Surplus lines;

(k) Travel insurance, as defined in section 10-2-414.5;

(l) Health maintenance organizations ("HMO"); except that no person shall be issued a new license for this individual line of authority on or after January 1, 2002, pursuant to section 10-2-402;

(m) Nonprofits; except that no person shall be issued a new license for this individual line of authority on or after January 1, 2002, pursuant to section 10-2-402;

(n) "Personal lines", which means property and casualty insurance sold to individuals and families for primarily noncommercial purposes; or

(o) Any other line of insurance permitted under state law or regulation.

(2) (Deleted by amendment, L. 2001, p. 1199, § 14, effective January 1, 2002.)

(3) An insurance producer license for surplus lines may be issued to resident persons pursuant to article 5 of this title.

Source: L. 93: Entire article R&RE, p. 1360, § 1, effective January 1, 1995. **L. 99:** (1)(f) amended, p. 988, § 6, effective January 1, 2000. **L. 2001:** IP(1), (1)(a), (1)(b), (1)(c), (1)(d), (1)(e), (1)(g), (1)(h), (1)(l), (1)(m), and (2) amended and (1)(n) and (1)(o) added, p. 1199, § 14, effective January 1, 2002. **L. 2008:** (1)(h) amended, p. 209, § 3, effective March 26. **L. 2012:** IP(1) amended and (1)(f) repealed, (HB 12-1266), ch. 280, p. 1494, § 9, effective July 1. **L. 2014:** (1)(k) amended, (HB 14-1185), ch. 202, p. 734, § 1, effective August 6.

Editor's note: This section is similar to former §§ 10-2-104, 10-2-111, 10-2-204, and 10-2-207 as they existed prior to 1993.

10-2-408. License - contents - continuation due date. (1) The commissioner shall issue a perpetual insurance producer license to an applicant who has met the requirements of section 10-2-404.

(2) The license shall state the name, address, and personal identification number of the licensee, the date of issuance, general conditions relative to expiration or cancellation, the line or lines of insurance covered by the license, and any other information the commissioner deems proper or necessary.

(3) The license issued to an individual, as a sole proprietor, shall include the trade name under which the licensee acts in the solicitation or negotiation of insurance contracts.

(4) Subject to continuation, each insurance producer license shall remain in effect unless revoked or suspended as long as the continuation fee as prescribed by the commissioner in accordance with section 10-2-413 is paid and education requirements are met on or before the due date.

(5) The commissioner shall establish, by rule, the continuation due date and application procedures for continuation of the license and for the acceptance of a late filing fee.

(6) Any person who holds either a Colorado insurance producer license, a resident surplus lines license, or the equivalent issued by another state or territory that offers Colorado surplus lines producers' nonresident licenses on a reciprocal basis and is deemed by the commissioner to be competent and trustworthy may be licensed as a surplus line producer upon the condition that the producer shall conduct business under the license in accordance with the provisions of this article and shall promptly remit the taxes provided by section 10-5-111.

(7) A licensed insurance producer who fails to comply with license continuation or renewal procedures due to military service, long-term medical disability, or any other condition the commissioner deems appropriate, may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with continuation or renewal procedures.

Source: L. 93: Entire article R&RE, p. 1361, § 1, effective January 1, 1995. **L. 95:** (6) amended, p. 489, § 1, effective May 16. **L. 2001:** (6) amended and (7) added, p. 1200, § 15, effective January 1, 2002.

Editor's note: This section is similar to former §§ 10-2-104, 10-2-111, and 10-2-207 as they existed prior to 1993.

10-2-409. License - amendment - reissuance. (1) An insurance producer licensee shall promptly notify the commissioner, on a form prescribed by the commissioner, of any change that will require amending a license to reflect that change, including without limitation a legal change of the licensee's name, a change of address, or change or removal of a trade name. The commissioner may require the licensee to furnish any documents necessary to verify any change and to properly amend the license.

(2) Repealed.

Source: L. 93: Entire article R&RE, p. 1362, § 1, effective January 1, 1995. **L. 2001:** (2) repealed, p. 1201, § 16, effective January 1, 2002.

10-2-410. Temporary licensing. (1) The commissioner may issue a temporary license to an individual to act as an insurance producer for a period not to exceed one hundred eighty days, without requiring an examination, if the commissioner deems that such temporary license authority is necessary for the servicing of an insurance business in the following cases:

(a) To the surviving spouse or next of kin, or to the executor or an employee, of a licensed insurance producer who becomes deceased;

(b) To the surviving spouse or next of kin, or to an employee or the legal guardian, of a licensed insurance producer who becomes disabled;

(c) To a member, employee, or officer of a licensed insurance agency or business entity, licensed as an insurance producer upon the death or disability of an individual designated in or registered as to the agency or business entity license;

(d) To the designee of a licensed insurance producer upon entering active service in the armed forces of the United States;

(e) To any person in any other circumstance where the commissioner deems that the public interest will best be served by the issuance of such license.

(2) The commissioner may, by order, limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee. The commissioner may impose other requirements designed to protect insureds and the public. The commissioner may, by order, revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

Source: L. 93: Entire article R&RE, p. 1362, § 1, effective January 1, 1995. **L. 2001:** IP(1) and (1)(c) amended and (2) added, p. 1201, § 17, effective January 1, 2002.

Editor's note: This section is similar to former § 10-2-219 as it existed prior to 1993.

10-2-411. Duplicate license. The commissioner may issue a duplicate license to any actively licensed insurance producer if such producer's license is lost, stolen, or destroyed upon an affidavit by the producer in a form prescribed and furnished by the commissioner concerning the facts of such loss, theft, or destruction.

Source: L. 93: Entire article R&RE, p. 1362, § 1, effective January 1, 1995. **L. 2001:** Entire section amended, p. 1202, § 18, effective January 1, 2002.

10-2-412. Change of address - notification. (1) Individual and insurance agency producer licensees shall inform the commissioner in writing, in a form prescribed by the commissioner, of any change of address within thirty days after the change.

(2) Failure of any licensee to inform the commissioner of any change to the licensee's address of record or residence address shall be grounds for the assessment of a penalty.

Source: L. 93: Entire article R&RE, p. 1362, § 1, effective January 1, 1995. **L. 2001:** Entire section amended, p. 1202, § 19, effective January 1, 2002.

10-2-413. Fees. (1) The commissioner shall, by rule, set reasonable fees and penalties for the following:

(a) Insurance producer license; and

(b) Continuation of license.

(2) All fees payable to the commissioner pursuant to this section shall be nonrefundable. Fees shall be set at the levels necessary to ensure that revenues from such fees, together with revenues from all other fees and taxes collected by the division of insurance in any fiscal year, do not exceed the division's actual direct and indirect costs of operation for that year.

Source: L. 93: Entire article R&RE, p. 1363, § 1, effective January 1, 1995. **L. 95:** (1)(t) and (1)(u) added, p. 90, § 4, effective March 30. **L. 99:** (1)(o), (1)(p), and (1)(r) repealed, p. 663, § 1, effective January 1, 2000. **L. 2001:** (1) amended, p. 1202, § 20, effective January 1, 2002.

Editor's note: This section is similar to former §§ 10-2-110 and 10-2-207 as they existed prior to 1993.

10-2-414. Additional lines of authority - application for license. An insurance producer licensee requesting licensure for any additional line or lines of authority shall comply with the requirements of section 10-2-404. Upon receipt of the application filing, any supporting documents as required by section 10-2-404, and the applicable fee, the commissioner may issue a replacement license to include the additional lines.

Source: L. 93: Entire article R&RE, p. 1364, § 1, effective January 1, 1995. **L. 2001:** Entire section amended, p. 1203, § 21, effective January 1, 2002.

Editor's note: This section is similar to former § 10-2-208 as it existed prior to 1993.

10-2-414.5. Travel insurance - limited lines license - travel insurance producers - definitions - rules. (1) As used in this section:

(a) "Limited lines travel insurance producer" means:

(I) A licensed insurance producer, including a limited line producer, who is designated by an insurer as the travel insurance supervising entity; or

(II) A travel administrator, as defined in section 10-4-1903 (11).

(b) "Offer and disseminate" means to provide general information about travel insurance, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other nonlicensable activities permitted by the state.

(c) (I) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including:

(A) Interruption or cancellation of a trip or event;

(B) Loss of baggage or personal effects;

(C) Damages to accommodations or rental vehicles;

(D) Sickness, accident, disability, or death occurring during travel;

(E) Emergency evacuation;

(F) Repatriation of remains; or

(G) Any other personal risks for which a contractual obligation exists to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel, as approved by the commissioner.

(II) "Travel insurance" does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six months, including a person working overseas as an expatriate, or any other product that requires a specific insurance producer license.

(d) "Travel retailer" means a business entity that makes, arranges, or offers travel services and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

(2) (a) (I) The commissioner may issue a limited lines travel insurance producer license to an individual or business entity that has filed an application with the commissioner in a form and manner prescribed by the commissioner and has paid all applicable licensing fees, as set forth in the applicable state law.

(II) A limited lines travel insurance producer must be licensed in order to sell, solicit, or negotiate travel insurance through a licensed insurer.

(III) A person shall not act as a limited lines travel insurance producer or travel retailer unless the person is properly licensed or registered as a limited lines travel insurance producer or travel retailer, respectively.

(b) A travel retailer may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a business entity that holds a limited lines travel insurance producer license. In doing so, the travel retailer or limited lines travel insurance producer shall provide to prospective purchasers of travel insurance:

(I) A description of the material terms or the actual material terms of the insurance coverage;

(II) A description of the process for filing a claim;

(III) A description of the review or cancellation process for the travel insurance policy; and

(IV) The identity and contact information of the insurer and limited line producer.

(c) (I) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf on a form prescribed by the commissioner. The limited lines travel insurance producer must maintain and update the register annually and include:

(A) The name, address, and contact information of each travel retailer;

(B) The name, address, and contact information of an officer or person who directs or controls the travel retailer's operations; and

(C) The travel retailer's federal tax identification number.

(II) The limited lines travel insurance producer shall submit the register to the commissioner upon request. The limited lines travel insurance producer shall also certify that the travel retailer registered is not in violation of 18 U.S.C. sec. 1033.

(III) The grounds for suspension and revocation and the penalties applicable to resident insurance producers under section 10-2-801 are applicable to limited lines travel insurance producers and travel retailers.

(d) The limited lines travel insurance producer must designate one of its employees who is a licensed individual producer as the person responsible for the limited lines travel insurance producer's compliance with the travel insurance laws and rules of the state.

(e) The limited lines travel insurance producer shall require each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the commissioner. The training material must include, at minimum, instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

(3) A limited lines travel insurance producer and those registered under its license are exempt from the prelicensure educational requirements in section 10-2-201, continuing education requirements in section 10-2-301, and examination and continuing education requirements in section 10-2-403.

(4) Any travel retailer offering or disseminating travel insurance shall make brochures or other written materials available to prospective purchasers that have been approved by the travel insurer. The materials must include information that, at a minimum:

(a) Provide the identity and contact information of the insurer and the limited lines travel insurance producer;

(b) Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(c) Explain that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(5) A travel retailer's employee or authorized representative who is not licensed as an insurance producer may not:

(a) Evaluate or interpret the technical terms, benefits, or conditions of the offered travel insurance coverage;

(b) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(c) Hold himself or herself out as a licensed insurer, licensed producer, or insurance expert.

(6) Notwithstanding any other provision of law, a travel retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this section is authorized to receive related compensation for the services upon registration by the limited lines travel insurance producer.

(7) Travel insurance may be provided under an individual, group, or blanket policy.

(8) The limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure that the travel retailer complies with this section.

(9) The commissioner may take disciplinary action against a limited lines travel insurance producer pursuant to section 10-2-801.

(10) Any person licensed in a major line of authority as an insurance producer is authorized to sell, solicit, and negotiate travel insurance. A property and casualty insurance producer is not required to be appointed by an insurer in order to sell, solicit, or negotiate travel insurance.

(11) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels, if those standards also meet the state's underwriting standards for inland marine.

(12) The commissioner may promulgate rules necessary to implement this section.

Source: L. 2014: Entire section added, (HB 14-1185), ch. 202, p. 734, § 2, effective August 6. **L. 2024:** (1)(a), (1)(c), (1)(d), (2)(a), IP(2)(b), (2)(c), IP(4), (6), and (7) amended and (10), (11), and (12) added, (HB 24-1060), ch. 128, p. 427, § 1, effective August 7.

10-2-415. Appointment of insurance producer by insurer - continuation - exceptions. (Repealed)

Source: L. 93: Entire article R&RE, p. 1364, § 1, effective January 1, 1995. **L. 99:** Entire section repealed, p. 663, § 2, effective January 1, 2000.

10-2-415.5. Appointment of insurance producer - continuation - renewal - exceptions. (1) No insurance producer shall claim to be a representative or authorized or appointed agent of, or use any other term implying a contractual relationship with, a particular bail insurance company or accept applications on behalf of the bail insurance company unless the insurance producer becomes through a written contract a producer appointee, appointed by that bail insurance company in accordance with this section, to act in the capacity of an agent of the bail insurance company.

(2) (a) A bail insurance company shall notify the commissioner of each insurance producer appointment. Each bail insurance company shall file with the commissioner, monthly or at such other less frequent intervals as the commissioner may prescribe, a current list of insurance producers that it has appointed to solicit business on its behalf. The list shall contain all relevant appointment information as prescribed by the commissioner, including the effective date of appointment.

(b) Subject to renewal, each insurance producer appointment shall remain in effect until:

(I) The insurance producer's license is allowed to expire, discontinued, or canceled by the insurance producer or revoked by the commissioner; or

(II) Notice of termination of the appointment is filed with the commissioner by the insurer.

(c) (I) A bail insurance company shall not appoint an insurance producer to act as its agent to write bail bonds unless the agent is licensed as an insurance producer authorized to write bail bonds and has completed the prelicensure education required by this paragraph (c) and submitted to the bail insurance company evidence of satisfactory completion of the education. The education must be approved by the division and consist of at least:

(A) Eight clock hours regarding bail bonding, two of which concern the criminal court system, two of which concern bail bond industry ethics, and four of which concern the bail bond laws; and

(B) Sixteen clock hours of training in bail recovery practices that complies with standards established by the peace officers standards and training board under section 24-31-303 (1)(h), C.R.S.

(II) This paragraph (c) does not apply to a person who has successfully completed the required prelicensure training pursuant to section 12-7-102.5, C.R.S., as it existed prior to July 1, 2012.

(III) A bail insurance company failing to comply with this paragraph (c) is subject to discipline under section 10-1-110 or the assessment of a penalty.

(3) Each active insurance producer appointment shall be subject to renewal on October 1 of the renewal year. The division shall provide a list of active insurance producer appointees to the bail insurance company along with a renewal invoice stating the fee required for the renewal of each active insurance producer appointment.

(4) Any appointment that is not renewed on or before October 1 shall be deemed to have expired or been discontinued, effective on that date; except that the commissioner may renew an insurer's appointment upon receipt of the renewal invoice together with the renewal fees due and any applicable late fee.

Source: L. 2004: Entire section added, p. 1749, § 1, effective July 1. **L. 2012:** (1), (2)(a), IP(2)(b), (2)(b)(I), and (3) amended and (2)(c) added, (HB 12-1266), ch. 280, p. 1494, § 10, effective July 1.

10-2-415.6. Bail bond reports required - repeal. (Repealed)

Source: L. 2012: Entire section added, (HB 12-1266), ch. 280, p. 1496, § 11, effective July 1.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 2015. (See L. 2012, p. 1496.)

10-2-415.7. Termination of insurance producer bail bonding agent - notice - penalty. (1) Upon the termination of the appointment of an insurance producer bail bonding agent, the insurer shall, within fifteen days, notify the commissioner and the appointee of such termination by certified mail.

(2) If the termination of an agent's appointment is for any of the causes listed in section 10-1-128 or 10-2-801, the insurer shall notify the commissioner of the reason and, if the commissioner so requests, the insurer shall provide any information, records, statements, or other data pertaining to the termination that may be used by the division in any action taken under section 10-2-801.

(3) Any information, documents, records, or statements provided pursuant to this section shall be privileged, and there shall be no liability on the part of, nor shall a cause of action of any nature arise against, the division, the insurance company, or any authorized representative for

requesting or providing such information, documents, records, or statements; except that such information may be used by the division to pursue administrative or criminal prosecutions.

(4) In addition to any other penalty or liability authorized by law, the failure or refusal of any insurer to comply with the requirements of subsection (1) or (2) of this section shall be cause for the assessment against the insurer of a civil penalty of up to one thousand dollars for each such failure or refusal if, after notice to the insurer and after a hearing in accordance with section 24-4-105, C.R.S., the commissioner finds that the insurer has violated this section.

Source: L. 2004: Entire section added, p. 1749, § 1, effective July 1. **L. 2012:** (2) amended, (HB 12-1266), ch. 280, p. 1497, § 12, effective July 1.

10-2-416. Notification to the commissioner of termination. (1) **Termination for cause.** An insurer or authorized representative of the insurer that terminates employment, a contract, or other insurance business relationship with a producer shall notify the commissioner within thirty days following the effective date of the termination, using a format prescribed by the commissioner, if the reason for termination is one of the reasons set forth in this article and article 3 of this title, or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in this article and article 3 of this title. Upon the written request of the commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

(2) **Ongoing notification requirement.** The insurer or the authorized representative of the insurer shall promptly notify the commissioner, in a format prescribed by the commissioner, if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the commissioner pursuant to subsection (1) of this section had the insurer known of its existence.

(3) **Copy of notification to be provided to producer.** A copy of the notification pursuant to this subsection (3) shall be provided to the producer pursuant to the following requirements:

(a) Within fifteen days after making the notification required by subsections (1) and (2) of this section, the insurer shall mail a copy of the notification to the producer at the producer's last-known address. If the producer is terminated for cause as listed in section 10-2-801, the insurer shall provide a copy of the notification to the producer at the producer's last-known address by certified mail, return receipt requested and postage prepaid, or by overnight delivery using a nationally recognized carrier.

(b) Within thirty days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (5) of this section.

(4) **Immunities.** (a) In the absence of wilful and wanton behavior, an insurer, the authorized representative of the insurer, a producer, the commissioner, or an organization of which the commissioner is a member and that compiles the information and makes it available to other commissioners or regulatory or law enforcement agencies shall not be subject to civil

liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the commissioner, from an insurer or producer or a statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under this paragraph (a) was reported to the commissioner, if the propriety of any termination for cause under subsection (1) of this section is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(b) Paragraph (a) of this subsection (4) shall not abrogate or modify any existing statutory or common law privileges or immunities.

(5) **Confidentiality.** (a) (I) Except as provided in paragraph (e) of this subsection (5), any documents, materials, or other information in the control or possession of the division of insurance that is furnished by an insurer, producer, or employee or agent thereof acting on behalf of the insurer or producer, or obtained by the commissioner in an investigation pursuant to this section, shall not be subject to article 72 of title 24, C.R.S.

(II) The commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties.

(b) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be required to testify in any private civil action concerning any confidential documents, materials, or information subject to paragraph (a) of this subsection (5).

(c) In order to assist in the performance of the commissioner's duties under this article, the commissioner, if the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information, and has the authority to do so, may:

(I) Share documents, materials, or other information, including the documents, materials, or information subject to paragraph (a) of this subsection (5), with any of the following:

(A) Other state, federal, and international regulatory agencies;

(B) The national association of insurance commissioners or its affiliates or subsidiaries; and

(C) State, federal, and international law enforcement authorities.

(II) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the national association of insurance commissioners, its affiliates or subsidiaries, and regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(III) Enter into agreements governing sharing and use of information consistent with this subsection (5).

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in paragraph (c) of this subsection (5).

(e) Nothing in this article shall preclude the commissioner or the commissioner's designee from releasing final disciplinary actions or closed files, including those portions of the

record pertaining to for cause terminations that shall be open to public inspection pursuant to article 72 of title 24, C.R.S., and to a database or other clearinghouse service maintained by the national association of insurance commissioners or its affiliates or subsidiaries.

(f) Nothing in this article shall preclude the commissioner or the commissioner's designee from disclosing any information obtained pursuant to the provisions of this article to any state, federal, or international law enforcement agency for use in any criminal or civil investigation or prosecution, nor shall any such information be considered privileged and confidential in any criminal or civil matter, investigation, or prosecution by a government agency, except as provided in part 3 of article 72 of title 24, C.R.S.

(g) Nothing in this article shall preclude the commissioner or the commissioner's designee from disclosing any information obtained or developed pursuant to the provisions of this article for use in any private civil matter, nor shall any such information be considered privileged or confidential, except as provided in part 3 of article 72 of title 24, C.R.S. Any party in interest may request the commissioner or the commissioner's designee to find that disclosure of such information in any private civil matter shall cause substantial injury to the public interest. If the commissioner finds that disclosure shall cause substantial injury to the public interest, the commissioner or the commissioner's designee may apply to the district court for an order permitting restrictions on disclosure as authorized by section 24-72-204 (6), C.R.S.

(6) **Penalties for failing to report.** An insurer, the authorized representative of the insurer, or producer that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction, may, after notice and hearing, have the producer's license or insurer's certificate of authority suspended or revoked and may be fined in accordance with sections 10-2-804 (4) and 10-3-1108.

Source: L. 93: Entire article R&RE, p. 1365, § 1, effective January 1, 1995. **L. 96:** (2) amended, p. 289, § 3, effective July 1. **L. 99:** Entire section repealed, p. 663, § 2, effective January 1, 2000. **L. 2001:** Entire section RC&RE, p. 1203, § 22, effective January 1, 2002.

Editor's note: This section is similar to former § 10-2-216 as it existed prior to 1993.

10-2-416.5. Required availability to commissioner of list of producer appointees for enforcement purposes. Each insurer shall maintain a current list of producers contractually authorized to accept applications on behalf of the insurer. Each insurer shall make such list available to the commissioner upon reasonable request for purposes of conducting investigations and enforcing the provisions of this title.

Source: L. 99: Entire section added, p. 663, § 3, effective January 1, 2000.

10-2-417. Public insurance adjusters - license required - financial responsibility - standards of conduct - rules. (1) (a) A person shall not act or hold himself or herself out as a public adjuster in this state unless the person is licensed as a public adjuster in accordance with this article. No person who, on or before January 1, 2014, holds a license as a public adjuster previously issued under the laws of this state is required to secure an additional license under this article, but is otherwise subject to this article including complying with the financial

responsibility requirements of subsection (2) of this section. The previously issued license is, for all purposes, considered a license issued under this article.

(b) A person licensed as a public adjuster shall not misrepresent to an insured that he or she is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster, unless so appointed by an insurer in writing to act on the insurer's behalf for that specific claim or purpose. A licensed public adjuster is prohibited from charging an insured a fee if the public adjuster accepts an appointment by the insurer.

(c) A business entity acting as a public adjuster is required to obtain a public adjuster license. Application shall be made in the form required by the commissioner. Before approving the application, the insurance commissioner shall find that:

(I) The business entity has paid the fees set by the commissioner; and

(II) The business entity has designated a licensed public adjuster responsible for the business entity's compliance with the insurance laws and rules of this state.

(2) (a) Before receiving a license as a public adjuster and for the duration of the license, the applicant shall secure evidence of financial responsibility in a format prescribed by the commissioner through a surety bond executed and issued by an insurer authorized to issue surety bonds in this state, which bond:

(I) Must be in the minimum amount of twenty thousand dollars;

(II) Must be in favor of this state and must specifically authorize recovery by the commissioner on behalf of any person in this state who sustained damages as the result of the applicant's erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices in his or her capacity as a public adjuster; and

(III) Must not be terminated unless at least thirty days' prior written notice is filed with the commissioner and given to the licensee.

(b) The issuer of the evidence of financial responsibility shall notify the commissioner upon termination of the bond, unless otherwise directed by the commissioner.

(c) The commissioner may ask for the evidence of financial responsibility at any time the commissioner deems relevant.

(d) The commissioner shall summarily suspend the authority to act as a public adjuster if the evidence of financial responsibility terminates or becomes impaired.

(3) A public adjuster shall not pay a commission, service fee, or other valuable consideration to a person for investigating or settling claims in this state if that person is required to be licensed under this article and is not licensed.

(4) In the event of a catastrophic disaster, no public adjuster shall charge, agree to, or accept as compensation or reimbursement any payment, commission, fee, or other thing of value in excess of ten percent of any insurance settlement or proceeds. No public adjuster shall require, demand, or accept any fee, retainer, compensation, deposit, or other thing of value prior to settlement of a claim.

(5) A public adjuster who receives, accepts, or holds any funds on behalf of an insured towards the settlement of a claim for loss or damage shall deposit the funds in a noninterest-bearing escrow or trust account in a financial institution that is insured by an agency of the federal government in the public adjuster's home state or where the loss occurred.

(6) (a) A public adjuster is obligated, under his or her license, to serve with objectivity and loyalty the interest of his or her client alone and to render to the insured such information,

counsel, and service, within the knowledge, understanding, and opinion in good faith of the licensee, as will best serve the insured's insurance claim needs and interests.

(b) A public adjuster shall not solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract.

(c) A public adjuster shall not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this article.

(d) A public adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, commission, or other consideration established in the written contract with the insured.

(e) A public adjuster shall not acquire any interest in salvage of property subject to the contract with the insured unless the public adjuster obtains written permission from the insured after settlement of the claim with the insurer.

(f) A public adjuster shall not refer or direct the insured to get needed repairs or services in connection with a loss from any person:

(I) With whom the public adjuster has a financial interest; or

(II) From whom the public adjuster may receive direct or indirect compensation for the referral.

(g) A public adjuster shall not participate directly or indirectly in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the public adjuster.

(h) A public adjuster shall not engage in any other activities that may reasonably be construed as presenting a conflict of interest, including soliciting or accepting any remuneration from, or having a financial interest in, any salvage firm, repair firm, or other firm that obtains business in connection with any claim the public adjuster has a contract or agreement to adjust.

(i) Public adjusters shall adhere to the following general ethical requirements:

(I) A public adjuster shall not undertake the adjustment of a claim if the public adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage or if the adjustment of the claim otherwise exceeds the public adjuster's expertise.

(II) A public adjuster shall not knowingly make any oral or written material misrepresentations or statements which are false and intended to injure any person engaged in the business of insurance to any insured client or potential insured client.

(III) A public adjuster, while licensed in this state, shall not represent or act as a company adjuster or independent adjuster on the same claim.

(IV) (A) The insured may rescind any contract or other form of agreement for representation in a property or casualty loss or claim if the insured exercises this right of rescission in writing addressed to the insurer and the public adjuster and puts the written rescission, postage prepaid, in the United States mail within seventy-two hours after signing a settlement representation agreement. All public adjusters taking a representative agreement to resolve a property or casualty loss or claim on behalf of an insured shall give to the insured written notice of, and direction as to, the ability to exercise the insured's right of rescission.

(B) A public adjuster shall not enter into a contract that prevents an insured from pursuing any civil remedy after the required rescission period under sub-subparagraph (A) of this subparagraph (IV).

(V) A public adjuster shall not enter into a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the persons who perform repair work.

(VI) A public adjuster shall ensure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement.

(j) A public adjuster shall not agree to any loss settlement without the insured's knowledge and consent.

(7) The commissioner may promulgate rules as necessary to carry out this section, including:

(a) Requirements and standards for written contracts between public adjusters and insureds; and

(b) The required retention of records by public adjusters.

Source: L. 95: Entire section added, p. 90, § 5, effective March 30. **L. 2013:** Entire section amended, (HB 13-1062), ch. 61, p. 202, § 4, effective January 1, 2014.

10-2-418. Bail bonding authority. (1) The division shall advise state court administrators that a person may furnish a bail bond if the person is a licensed insurance producer with a power of attorney from an insurance company, appears on the division's website as an active insurance producer with casualty authority, and is appointed by that insurance company.

(2) The division shall issue credentials to each insurance producer who is appointed by a bail insurance company that clearly identifies the person as holding authority to act as a bail bond agent.

Source: L. 2012: Entire section added, (HB 12-1266), ch. 280, p. 1497, § 13, effective July 1.

PART 5

NONRESIDENT LICENSES

10-2-501. Reciprocity. (1) The commissioner shall waive any requirements for a nonresident license applicant with a valid license from the applicant's home state, except those requirements imposed by section 10-2-502, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

(2) A nonresident producer's satisfaction of a nonproducer's home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this state's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.

Source: L. 93: Entire article R&RE, p. 1366, § 1, effective January 1, 1995. **L. 2001:** Entire section R&RE, p. 1206, § 23, effective January 1, 2002.

10-2-502. Nonresident licensing - qualification. (1) The commissioner may qualify an applicant as a nonresident, unless the applicant is denied licensure pursuant to section 10-2-801, and shall issue an insurance producer license to any qualified nonresident person in accordance with the following:

(a) The person maintains a license in good standing in the person's home state;

(b) An insurance agency or business entity may qualify as a nonresident if the agency or business entity has its principal office located in another state;

(c) The nonresident person holds a similar license that is awarded on the same basis in the nonresident's home state and for the same line or lines of authority applied for in this state;

(d) The person has submitted the proper request for licensure and has paid the fees set forth by regulation;

(e) The nonresident person has filed with the commissioner a current certification of license status for the purposes set forth in section 10-2-501;

(f) The person has submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to his or her home state, or in lieu of the application, a completed uniform application.

(2) The commissioner may verify the producer's licensing status through the producer database maintained by the national association of insurance commissioners or its affiliates or subsidiaries.

(3) A license issued to a nonresident person shall confer the same rights and privileges as those afforded a resident licensee.

(3.5) A nonresident producer who moves from one state to another state or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty days after the change of legal residence. No fee or license application is required.

(4) If the insurance department of the nonresident insurance producer's resident state suspends, terminates, or revokes the producer's insurance license in that state, the nonresident insurance producer shall notify the commissioner and shall return the Colorado nonresident license pursuant to section 10-2-804.

(5) Notwithstanding any other provision of this article, a person licensed as a surplus lines producer in the surplus lines producer's home state shall receive a nonresident surplus lines producer license pursuant to subsection (1) of this section; except that nothing in this section otherwise amends or supercedes any provision of this part 5.

(6) Notwithstanding any other provision of this article, a person licensed as a limited lines credit insurance or other type of limited line producer in the limited line producer's home state shall receive a nonresident limited line producer license, pursuant to subsection (1) of this section, granting the same scope of authority granted under the license issued by the producer's home state. For the purposes of this subsection (6), limited lines insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section 10-2-407.

Source: L. 93: Entire article R&RE, p. 1366, § 1, effective January 1, 1995. **L. 2001:** (1), (2), and (3) amended and (3.5), (5), and (6) added, p. 1206, § 24, effective January 1, 2002. **L. 2012:** IP(1) amended, (HB 12-1266), ch. 280, p. 1497, § 14, effective July 1.

10-2-503. Commissioner as agent for service of process. (1) By the filing of the application and issuance of a nonresident insurance producer license, a nonresident insurance producer licensee shall be deemed to have appointed the commissioner and successors in office as said nonresident's agent upon whom all lawful process in any legal proceeding against the nonresident may be served and to have agreed that any such lawful process has the same legal force and validity as personal service of process upon such nonresident.

(2) The commissioner shall, within ten working days after receiving three copies of the process served, forward a copy of such process by registered or certified mail to the person for whom the commissioner has received such process at the nonresident individual's address of record, or, if the nonresident is an insurance agency, at the agency's principal place of business. The commissioner shall keep a record of all process so served.

(3) Service of process upon any such licensee in any action or proceeding instituted by the commissioner under this section shall be made by the commissioner by mailing such process by registered mail to an individual licensee at the licensee's last-known address of record or to an insurance agency licensee at its principal place of business.

Source: L. 93: Entire article R&RE, p. 1367, § 1, effective January 1, 1995. **L. 98:** (2) amended, p. 1325, § 25, effective June 1. **L. 2001:** (2) amended, p. 1208, § 25, effective January 1, 2002.

PART 6

BANKS AND BANK HOLDING COMPANIES

10-2-601. Financial institutions may sell insurance - where - regulation. (1) For the purposes of this part 6:

(a) and (b) (Deleted by amendment, L. 97, p. 426, § 1, effective April 24, 1997.)

(c) "Credit insurance" has the same meaning as set forth in section 10-10-103 (2).

(d) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

(e) "Financial institution" means a state bank, including a bank and trust company chartered by a state, a trust company, a savings and loan association, a credit union, or a national bank and the financial institution is located in this state. "Financial institution" includes federally chartered savings and loan associations and credit unions located in this state.

(2) No financial institution or employee thereof shall be licensed or admitted, directly or indirectly, to sell insurance in this state; except that:

(a) A financial institution or employee thereof may engage in the activities of an insurance producer, an insurance agency, or a business entity in this state and shall be licensed pursuant to this article. Such producers, agencies, and business entities shall be subject to the provisions of this title and rules promulgated pursuant thereto.

(b) Unlicensed employees of financial institutions shall not sell insurance or annuities. Such employees may direct customers to licensed persons.

(c) A financial institution, or any subsidiary, affiliate, or employee thereof, may be licensed to sell insurance, credit insurance, and fixed and variable annuity contracts in accordance with regulations promulgated by the commissioner.

(d) Any financial institution, or any subsidiary, affiliate, or employee thereof, may be permitted to own an insurance company authorized to sell, and that insurance company's employees may be licensed to sell, insurance to guarantee the payment of any amounts due in connection with any securities or obligations described in section 11-57-101, C.R.S.; except that no financial institution, or any subsidiary or affiliate subject to the supervision of the banking board created in section 11-102-103, C.R.S., shall own such an insurance company without the consent of the banking board, and no financial institution subject to the supervision of the financial services board created in section 11-44-101.6, C.R.S., shall own such an insurance company without the consent of the financial services board, and no financial institution shall invest more than ten percent of its capital and surplus in such an insurance company.

(e) Any financial institution, or any subsidiary or affiliate thereof, may own, directly or indirectly, a captive insurance company operating under article 6 of this title.

(f) Any trade association organized primarily to promote the common interests of financial institutions, or an affiliate or subsidiary of such association, may hold stock or other interests in an insurance company, or an affiliate or subsidiary thereof.

(3) and (4) (Deleted by amendment, L. 97, p. 426, § 1, effective April 24, 1997.)

(5) The commissioner shall promulgate such rules as are necessary to implement this part 6.

Source: L. 93: Entire article R&RE, p. 1367, § 1, effective January 1, 1995. **L. 94:** (2)(a) amended, p. 1353, § 4, effective January 1, 1995. **L. 97:** IP(1), (1)(a), (1)(b), and (2) to (5) amended and (1)(e) added, p. 426, § 1, effective April 24. **L. 99:** (1)(e) amended, p. 585, § 1, effective May 17. **L. 2001:** (2)(a) amended, p. 1208, § 26, effective January 1, 2002. **L. 2003:** (2)(d) amended, p. 1206, § 4, effective July 1. **L. 2013:** (1)(e) amended, (SB 13-154), ch. 282, p. 1470, § 27, effective July 1.

Editor's note: This section is similar to former § 10-2-221 as it existed prior to 1993.

10-2-602. Sale of annuities and insurance by financial institutions - certain tying arrangements prohibited. (1) In addition to the requirements of section 10-3-1105, no financial institution, or subsidiary or employee of a financial institution, shall extend credit, lease or sell property of any kind, furnish any service, or fix or vary the consideration for any such extension of credit, lease, sale, or service on the condition or requirement that the customer shall obtain an insurance contract or an annuity from such financial institution or any subsidiary or employee.

(2) No financial institution may offer a financial product or service, or fix or vary the conditions of such product or service, conditioned on a requirement that the customer obtain insurance from such financial institution or any specific person.

(3) No person shall require or imply that the purchase of an insurance product, or of an annuity from a financial institution, is a condition of the lending of money or extension of credit, maintenance of a trust account, establishment or maintenance of a checking, savings, deposit, or share account, or the provision of products or services related to such activities.

Source: L. 94: Entire section added, p. 1353, § 3, effective January 1, 1995. **L. 97:** Entire section amended, p. 429, § 2, effective April 24.

10-2-603. Bank sale of annuities - disclosure requirements. (1) Any financial institution, or any subsidiary or employee thereof, which sells a fixed or variable annuity contract shall receive written acknowledgment from the purchaser that the annuity which is being purchased may involve investment risk and is not insured by the federal deposit insurance corporation or the national credit union share insurance fund. Such written notice shall be clear and conspicuous and shall be given before or contemporaneously with the purchase of the annuity. This subsection (1) shall apply to an affiliate or subsidiary of a financial institution if such an affiliate or subsidiary sells insurance on the premises of a financial institution.

(2) A clear and conspicuous notice substantially in the following form complies with this section:

Acknowledgment

_____

(Complete name of investment)

I understand that the investment product I am purchasing is not a bank deposit and is not an obligation of, nor is it guaranteed by, any bank. This product is not insured or guaranteed by the federal deposit insurance corporation. In addition, I understand that the investment product purchased may be subject to investment risk, including possible loss of principal, and that any investment product's past performance should not be considered an indication of future results.

_____

(Date)

(Signed)

Source: L. 94: Entire section added, p. 1354, § 7, effective July 1, 1995. **L. 97:** (1) amended, p. 429, § 3, effective April 24.

10-2-604. Disclosures. (1) A financial institution, and any person selling insurance with a cash value or a cash accumulation component on behalf of a financial institution, shall disclose to the financial institution's customers or members, and on any advertisements or promotional material, that insurance offered, recommended, sponsored, or sold by the financial institution, or on the premises of the financial institution:

(a) Is not a deposit;

(b) Is not insured by the federal deposit insurance corporation, the national credit union share insurance fund, or any agency of the state of Colorado or the federal government;

(c) Is not guaranteed by the financial institution or any affiliated insured depository institution;

(d) May involve investment risk, including loss of principal; and

(e) May be purchased from a producer of the customer's choice and that the customer's choice of another insurance provider will not affect the customer's relationship with the financial institution.

Source: L. 97: Entire section added, p. 429, § 4, effective April 24. **L. 2001:** (1)(e) amended, p. 1208, § 27, effective January 1, 2002.

10-2-605. Misleading advertising. (1) No financial institution, or any subsidiary, affiliate, or employee of a financial institution, may issue advertising that would lead a reasonable person to believe that the state of Colorado or the federal government:

(a) Is responsible for insurance sales activities of the financial institution or any subsidiary, affiliate, or employee thereof;

(b) Guarantees any return on insurance products or is a source of payment of any insurance obligations sold by the financial institution or any subsidiary, affiliate, or employee thereof.

Source: L. 97: Entire section added, p. 430, § 4, effective April 24.

10-2-606. Discrimination against affiliated agents. (1) No financial institution shall:

(a) Require, as a condition of providing or renewing a contract for providing a product or service to any customer, that the customer purchase, finance, or negotiate any policy or contract of insurance through any particular person;

(b) In connection with a loan or extension of credit that requires a borrower to obtain insurance, reject an insurance policy solely because such policy has been issued or underwritten by any person who is not associated with such institution;

(c) Impose any requirement on any insurance producer who is not associated with the financial institution that is not imposed on any insurance producer who is associated with such institution; or

(d) Unless otherwise authorized by applicable federal or state law, require any debtor, insurer, or producer to pay a separate charge in connection with the handling of insurance that is required under a contract.

Source: L. 97: Entire section added, p. 430, § 4, effective April 24. **L. 2001:** (1)(c) and (1)(d) amended, p. 1209, § 28, effective January 1, 2002.

10-2-607. Location of sales. To the extent practicable, a financial institution's sale of insurance shall be in a location distinct from a teller window or common teller area. Unlicensed employees of financial institutions shall not sell insurance or annuities. Such employees may direct customers to licensed persons.

Source: L. 97: Entire section added, p. 431, § 4, effective April 24.

PART 7

BUSINESS CONDUCT OF LICENSEES

10-2-701. Assumed names - registration - rules. Any insurance producer using an assumed name, including without limitation a trade or fictitious name, under which the insurance producer conducts business shall register the name with the insurance commissioner prior to

using the assumed name. The commissioner shall not accept registration of any name that would tend to be misleading to the public or that is identical or similar to the name of any producer whose license has been revoked or suspended. Every insurance producer licensee shall promptly file with the commissioner a written notice of any change in or discontinuation of the use of any name. The commissioner may promulgate all rules necessary and proper to implement the provisions of this section.

Source: L. 93: Entire article R&RE, p. 1370, § 1, effective January 1, 1995. **L. 2001:** Entire section amended, p. 1209, § 29, effective January 1, 2002. **L. 2008:** Entire section amended, p. 210, § 4, effective March 26.

10-2-702. Commissions. (1) No insurer or insurance producer shall pay, directly or indirectly, any commission, service fee, brokerage, or other valuable consideration to any person selling, soliciting, or negotiating insurance within this state unless, at the time such services were performed, such person was a duly licensed insurance producer under this article for the performance of such services. In addition, no person, other than a person appropriately licensed by this state as an insurance producer at the time such services were performed, shall accept any such consideration; except that any person duly licensed under this article may pay or assign such person's commissions to, or direct that such person's commissions be paid to, a partnership of which the person is a member, employee, or agent or to a corporation of which the person is an officer, employee, or agent. This section shall not prevent payment or receipt of renewal or other deferred commissions to or by any person entitled thereto under this section.

(2) An insurer or insurance producer may pay or assign commissions, service fees, brokerages, or other valuable consideration to an insurance agency, business entity, or persons who do not sell, solicit, or negotiate insurance in this state, unless the payment would violate section 10-3-1104 (1)(g).

Source: L. 93: Entire article R&RE, p. 1370, § 1, effective January 1, 1995. **L. 95:** Entire section amended, p. 89, § 2, effective March 30. **L. 2001:** Entire section amended, p. 1209, § 30, effective January 1, 2002. **L. 2012:** (2) amended, (HB 12-1266), ch. 280, p. 1497, § 15, effective July 1.

10-2-703. Countersignature not required. (Repealed)

Source: L. 93: Entire article R&RE, p. 1370, § 1, effective January 1, 1995. **L. 2001:** Entire section repealed, p. 1210, § 31, effective January 1, 2002.

10-2-704. Fiduciary responsibilities. (1) (a) All premiums belonging to insurers and all unearned premiums belonging to insureds received by an insurance producer licensee under this article shall be treated by such insurance producer in a fiduciary capacity. The commissioner may promulgate such rules as are necessary and proper relating to the treatment of such premiums.

(b) All premiums received, less commissions if authorized, shall be remitted to the insurer or its agent entitled thereto on or before the contractual due date or, if there is no contractual due date, within forty-five days after receipt.

(c) All returned premiums received from insurers or credited by insurers to the account of the licensee shall be remitted to or credited to the account of the person entitled thereto within thirty days after such receipt or credit.

(d) If any insurance producer has failed to account for any collected premium to the insurer to whom it is owing or to its agent entitled thereto for more than forty-five days after the contractual due date or, if there is no contractual due date, more than ninety days after receipt, the insurer or its agent shall promptly report such failure to the commissioner in writing.

(2) Every insurer shall remit unearned premiums to the insured or the proper agent, or shall otherwise credit the account of the proper licensee, as soon as is practicable after entitlement thereto has been established, but in no event more than forty-five days after the effective date of any cancellation or termination effected by the insurer or after the date of entitlement thereto as established by notification of cancellation or of termination or as otherwise established. It shall be the responsibility of any insurance producer having knowledge of a failure on the part of any insurer to comply with this subsection (2) to promptly report such failure to the commissioner in writing.

(3) No insurance producer under this article shall commingle premiums belonging to insurers and returned premiums belonging to insureds with the producer's personal funds or with any other funds except those directly connected with the producer's insurance business.

(4) Any insurer that delivers, in this state, a policy of insurance to an insurance producer representing the interest of the insured upon the application or request of such producer shall be deemed to have authorized such producer to receive on the insurer's behalf any premium due upon issuance or delivery of the policy; and the insurer shall be deemed to have so authorized the producer.

Source: L. 93: Entire article R&RE, p. 1370, § 1, effective January 1, 1995. **L. 2001:** (4) amended, p. 1210, § 32, effective January 1, 2002.

10-2-705. Bail bond documents - requirements - rules. (1) The insurance producer who posts a bail bond with the court on behalf of a defendant shall ensure that the following documents comply with the following provisions:

(a) An indemnity agreement must:

(I) Be in writing;

(II) Be signed by the producer;

(III) Be signed by the defendant or indemnitor;

(IV) Set forth the amount of bail set in the case, the name of the defendant released on the bail bond, the court case number if available, the court where the bond is executed, the premium charged, the amount and type of collateral held by the insurance producer, and the conditions under which the collateral is returned;

(V) Contain documentation that the indemnitor has received copies of signed and dated disclosure forms; and

(VI) If the defendant or indemnitor is illiterate or does not read English, contain a note on the indemnity agreement that the producer or a third party has read or translated the agreement to the defendant or indemnitor and be affixed with an affidavit to the indemnity agreement attesting that the document was translated;

(b) A promissory note must be:

(I) In writing;

(II) Signed by the producer; and

(III) Signed by the defendant or indemnitor;

(c) A collateral receipt must:

(I) Be dated;

(II) Be in writing;

(III) Be signed by the producer;

(IV) Be signed by the defendant or indemnitor;

(V) Be prenumbered;

(VI) Contain a full description of the collateral, including the condition of the collateral at the time it is taken into custody; and

(VII) Set forth the amount of bail set in the case, the name of the defendant released on the bail bond, the court case number, the court where the bond is executed, the premium charged, the amount and type of collateral held by the insurance producer, and the conditions under which the collateral is returned;

(d) A bail bond revocation request must be:

(I) Dated;

(II) In writing;

(III) Signed by the producer; and

(IV) Signed by the defendant or indemnitor.

(2) (a) Before accepting consideration, the insurance producer who writes bail bonds shall commit to writing, sign, date, and obtain the defendant's or indemnitor's signature on an arrangement for the payment of all or part of the premium, commission, or fee, including the payment schedule. The signature of the insurance producer who writes bail bonds is not an obligation to pay any debt owed to a lender. To be enforceable, interest and financial charges on any unpaid premium must comply with the "Uniform Consumer Credit Code", articles 1 to 9 of title 5, C.R.S.

(b) Before accepting consideration or taking collateral, the insurance producer who writes bail bonds shall provide, in a form prescribed by the commissioner, a disclosure statement to each defendant and indemnitor detailing the terms of the bail bond.

(3) (a) An insurance producer who posts a bail bond with the court and who accepts consideration for a bail bond or undertaking shall, for each payment received, provide to the person tendering payment a prenumbered, signed receipt containing the following:

(I) The date;

(II) The defendant's name;

(III) A description of the consideration and amount of money received;

(IV) The purpose for which it was received;

(V) The number of any power-of-attorney form attached to the bail bond;

(VI) The penal sum of the bail bond;

(VII) The name of the person tendering payment; and

(VIII) The terms under which the money or other consideration is released.

(b) The insurance producer who posts a bail bond with the court shall provide the person tendering payment a signed and dated receipt for each premium payment listing the amount paid.

(3.5) (a) If the bond is to be secured by real estate, the bail bonding agent shall provide the property owner with a written disclosure statement in the following form at the time an initial application is filed:

Disclosure of lien against real property

Do not sign this document until you read and understand it! This bail bond will be secured by real property you own or in which you have an interest. Failure to pay the bail bond premiums when due or the defendant's failure to comply with the conditions of bail could result in the loss of your property!

(b) The disclosure required in paragraph (a) of this subsection (3.5) shall be printed in fourteen-point, bold-faced type either:

(I) On a separate and specific document attached to or accompanying the application; or

(II) In a clear and conspicuous statement on the face of the application.

(c) Before a property owner executes any instrument creating a lien against real property, the bail bonding agent shall provide the property owner with a completed copy of the instrument creating the lien against real property and the disclosure statement described in paragraph (a) of this subsection (3.5). If a bail bonding agent fails to comply fully with the requirements of paragraphs (a) and (b) of this subsection (3.5) and this paragraph (c), any instrument creating a lien against real property shall be voidable.

(d) The bonding agent shall deliver to the property owner a fully executed and notarized reconveyance of title, a certificate of discharge, or a full release of any lien against real property that secures performance of the conditions of a bail bond within thirty-five days after receiving notice that the time for appealing an order that exonerated the bail bond has expired. The bonding agent shall also deliver to the property owner the original canceled note as evidence that the indebtedness secured by any lien instrument has been paid or that the purposes of said instrument have been fully satisfied and the original deed of trust, security agreement, or other instrument that secured the bail bond obligation. If a timely notice of appeal is filed, the thirty-five-day period shall begin on the day the appellate court's affirmation of the order becomes final. If the bonding agent fails to comply with the requirements of this paragraph (d), the property owner may petition the district court to issue an order directing the clerk of such court to execute a full reconveyance of title, a certificate of discharge, or a full release of any lien against real property created to secure performance of the conditions of the bail bond. The petition shall be verified and shall allege facts showing that the bonding agent has failed to comply with the provisions of this paragraph (d).

(e) Any bail bonding agent who violates this subsection (3.5) is liable to the property owner for all damages that may be sustained by reason of the violation, plus statutory damages in the sum of three hundred dollars. The property owner shall be entitled to recover court costs and reasonable attorney fees, as determined by the court, upon prevailing in any action brought to enforce the provisions of this subsection (3.5).

(4) The insurance producer shall prepare or execute separate agreements and documents for each time the producer posts a bail bond with the court. The producer shall give the indemnitor a copy of each document executed in the course of the bail bond transaction.

(5) For three years after the date of discharge of a bail bond and return of any collateral or proof of notice to the defendant or indemnitor that any promissory note has been satisfied, the

insurance producer who posts the bail bond with the court shall keep at the producer's business copies of each receipt, indemnity agreement, bond, disclosure statement, payment plan, bond revocation request, or other document or information related to the bond transaction the commissioner reasonably requires by rule and shall make these documents available for inspection by the commissioner or the commissioner's authorized representative during normal business hours.

(6) The indemnitor may be the defendant.

(7) The commissioner may examine the business practices, books, and records of any insurance producer as often as the commissioner deems appropriate.

Source: L. 2012: Entire section added, (HB 12-1266), ch. 280, p. 1498, § 16, effective July 1. **L. 2013:** (3.5) added, (HB 13-1236), ch. 202, p. 840, § 6, effective May 11.

10-2-706. Insurance producer designee - responsibility. An insurance producer may use another properly licensed and appointed insurance producer as an agent to comply with the requirements of section 10-2-705, but the insurance producer who posts the bail bond with the court is responsible for compliance with section 10-2-705 and is subject to discipline for noncompliance with any provision of section 10-2-705.

Source: L. 2012: Entire section added, (HB 12-1266), ch. 280, p. 1500, § 16, effective July 1. **L. 2013:** Entire section amended, (HB 13-1300), ch. 316, p. 1664, § 12, effective August 7.

10-2-707. Business practices - price limits - collateral. (1) An insurance producer who writes bail bonds shall not charge a premium or commission of more than the greater of fifty dollars or fifteen percent of the amount of bail furnished. An insurance producer who writes bail bonds shall not assess fees for any bail bond posted by the producer with the court unless the fee is for payment of a bail bond filing charged by a court or law enforcement agency, the fee is for the actual cost of storing collateral in a secure, self-service public storage facility, or the fee is for premium financing.

(2) If an insurance producer who posts the bail bond with the court has issued a disclosure statement in accordance with section 10-2-705 (2)(b), the producer may use collateral received from the defendant or indemnitor to secure the following obligations:

(a) Compliance with the bond issued on behalf of the principal;

(b) Any balance due on the premium, commission, or fee for the bail bond; and

(c) Any actual costs incurred by the insurance producer as a result of issuing the bail bond.

(3) Subject to section 16-4-110 (1)(c) and (2), a bail premium is earned in its entirety by a compensated surety upon the defendant's release from custody.

Source: L. 2012: Entire section added, (HB 12-1266), ch. 280, p. 1500, § 16, effective July 1. **L. 2017:** (3) added, (HB 17-1231), ch. 284, p. 1575, § 11, effective January 1, 2018.

PART 8

10-2-801. Licenses - denial, suspension, revocation, termination - reporting of actions - definitions. (1) The commissioner may place an insurance producer on probation; suspend, revoke, or refuse to issue, continue, or renew an insurance producer license; order restitution to be paid from an insurance producer; or assess a civil penalty pursuant to section 10-2-804 or 10-3-1108, if, after notice to the insurance producer licensee and after a hearing held in accordance with sections 24-4-104 and 24-4-105, C.R.S., the commissioner finds that as to the licensee or applicant any one or more of the following conditions exist:

(a) Any incorrect, misleading, incomplete, or materially untrue information in the license application;

(b) Any cause for which issuance of the license could have been refused had it then existed and been known to the commissioner at the time of issuance;

(c) Violation of, or noncompliance with, section 18-13-130, C.R.S., or any insurance law, or violation of any lawful rule, order, or subpoena of the commissioner or of the insurance department of another state;

(d) Obtaining or attempting to obtain any such license through misrepresentation or fraud;

(e) Improperly withholding, misappropriating, or converting to the licensee's or applicant's own use any moneys or property belonging to policyholders, insurers, beneficiaries, or others received in the course of the business of insurance;

(f) Misrepresentation of the terms of any actual or proposed insurance contract or application for insurance;

(g) (I) Conviction of a felony or misdemeanor involving moral turpitude.

(II) For the purposes of this paragraph (g), "moral turpitude" shall include any sexual offense against a child as defined in section 18-3-411, C.R.S.

(h) Commission of any unfair trade practice or fraud;

(i) The use of fraudulent, coercive, or dishonest practices or demonstrating incompetence, untrustworthiness, or financial irresponsibility in this state or elsewhere;

(j) Suspension, revocation, or denial of an insurance license in any other state, province, district, or territory;

(k) Forgery of another's name to an application for insurance or to any document related to an insurance transaction;

(l) Cheating on an examination, including, but not limited to, improperly using notes or any other reference material to complete an examination for an insurance license;

(m) Failure to fully meet the licensing requirements;

(n) Knowingly accepting insurance business from a person who is not licensed;

(o) Failing to comply with an administrative or court order imposing a child support obligation;

(p) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax; or

(q) Profiting either directly or indirectly from the business of a cash-bonding agent or professional cash-bail agent unless the person profiting is registered as a cash-bonding agent or professional cash-bail agent and the profit is derived from their own business.

(1.5) The commissioner shall revoke the license of an insurance producer licensee if, after notice to the insurance producer licensee and after a hearing held in accordance with sections 24-4-104 and 24-4-105, C.R.S., the commissioner finds that the licensee was convicted under section 18-5-211, C.R.S.

(2) In the event that the action by the commissioner is to not renew or continue or to deny an application for a license, the commissioner shall notify the applicant or licensee of the reasons for such action and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license.

(3) (a) A producer or business entity shall report to the commissioner any administrative action taken against the producer in another jurisdiction or by another governmental agency in this state within thirty days after the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal document.

(b) A producer shall report within thirty days after the conviction to the commissioner if he or she is convicted under section 18-5-211, C.R.S.

(4) Within thirty days after the initial pretrial hearing date, a producer or business entity shall report to the commissioner any criminal prosecution of the producer in any jurisdiction. The report shall include a copy of the initial complaint, the order resulting from the hearing, and any other relevant legal documents.

(5) If the commissioner revokes the license of an insurance producer pursuant to this section, or if an insurance producer surrenders its license to avoid discipline by the commissioner, the insurance producer shall not be eligible to apply for a new insurance producer license for two years after the date the license is revoked or surrendered and returned to the commissioner pursuant to section 10-2-802 (1).

(6) For the purposes of this section, "restitution" means benefits or moneys owed due to the regulated entity's violation of this title.

Source: L. 93: Entire article R&RE, p. 1371, § 1, effective January 1, 1995. **L. 2001:** Entire section amended, p. 1210, § 33, effective January 1, 2002. **L. 2008:** (5) added, p. 210, § 5, effective March 26; IP(1) amended and (6) added, p. 585, § 1, effective August 5. **L. 2012:** (1)(c) amended and (1)(q) added, (HB 12-1266), ch. 280, p. 1501, § 17, effective July 1. **L. 2014:** (1.5) added and (3) amended, (SB 14-092), ch. 190, p. 710, § 2, effective July 1.

Editor's note: This section is similar to former §§ 10-2-115, 10-2-116, 10-2-117, and 10-2-212 as they existed prior to 1993.

10-2-802. Surrender of license. (1) An insurance producer license issued under this article, although issued and delivered to the licensee, shall at all times be the property of the state of Colorado and shall be surrendered or returned promptly to the commissioner by personal delivery or by certified or registered mail within fifteen days under any of the following conditions:

(a) Suspension, revocation, or termination of the license;

(b) Discontinuation or nonrenewal of the license by the licensee;

(c) Cessation of residency in this state or, in the case of a nonresident licensee, cessation of residency in the licensee's resident state; or

(d) Suspension, termination, or revocation of a nonresident licensee's license in the state of residence.

(2) The commissioner may require surrender of an insurance producer license for any proper reason in addition to the grounds stated in subsection (1) of this section.

(3) As to any insurance producer license issued pursuant to this article which is lost, stolen, or destroyed while in the possession of the licensee, the commissioner may accept, in lieu of return of the license, the affidavit of the individual licensee or, in the case of an insurance agency or business entity, the person given responsibility for custody of the license, as to the facts concerning such loss, theft, or destruction.

Source: L. 93: Entire article R&RE, p. 1372, § 1, effective January 1, 1995. **L. 2001:** (3) amended, p. 1212, § 34, effective January 1, 2002.

Editor's note: This section is similar to former §§ 10-2-115, 10-2-116, 10-2-117, 10-2-207, and 10-2-215 as they existed prior to 1993.

10-2-803. Notice of penalty, suspension, termination, revocation, or denial. (1) The commissioner shall promptly notify any insurance producer licensee regarding any penalty assessed, suspension, revocation, termination, or denial of the licensee's license by the commissioner.

(2) Upon assessment of a penalty, suspension, revocation, or termination of the license of a resident licensee, the commissioner shall notify the central office of the national association of insurance commissioners or its affiliate or subsidiary.

Source: L. 93: Entire article R&RE, p. 1373, § 1, effective January 1, 1995. **L. 2001:** Entire section amended, p. 1212, § 35, effective January 1, 2002.

10-2-804. Investigation by commissioner. (1) The commissioner may examine and investigate the business affairs and conduct of every person applying for or holding an insurance producer license under this article to determine whether such person has been or is engaged in any violation of the insurance laws or rules of this state or has engaged in unfair or deceptive acts or practices in any state.

(2) On receipt of any information regarding the possible violation of the insurance laws or rules of this or any other state, or the possible use of unfair or deceptive practices by a person applying for or holding an insurance producer license under this article, the commissioner may require such person to appear and show cause why the commissioner should not discontinue, revoke, suspend, or refuse to issue or renew the person's license and may, upon the failure of such person to show cause, revoke, suspend, or refuse to issue or renew the license.

(3) The license of an insurance agency or business entity may be suspended or revoked or the renewal or continuation refused if the commissioner finds, after hearing, that an individual licensee's violation was known or should have been known to one or more of the partners, officers, or managers acting on behalf of the insurance agency or business entity, including any foreign or domestic entity as defined in section 7-90-102, C.R.S., and that such violation was not reported to the division of insurance nor corrective action taken in relation thereto.

(4) In addition to or in lieu of any applicable denial, suspension, or revocation of an insurance producer license, any person who violates any provision of this article may, after hearing, be subject to any remedy or civil penalty of not more than three thousand dollars for each such violation.

(5) The commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this article against any person who is under investigation for or charged with a violation of this article even if the person's license has been surrendered or has lapsed by operation of law.

Source: L. 93: Entire article R&RE, p. 1373, § 1, effective January 1, 1995. **L. 2001:** (2), (3), and (4) amended and (5) added, p. 1212, § 36, effective January 1, 2002. **L. 2008:** (4) amended, p. 2171, § 2, effective August 5.

Editor's note: This section is similar to former § 10-2-214 as it existed prior to 1993.

PART 9

REINSURANCE INTERMEDIARY MODEL ACT

10-2-901. Short title. This part 9 shall be known and may be cited as the "Reinsurance Intermediary Act".

Source: L. 93: Entire article R&RE, p. 1374, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-301 as it existed prior to 1993.

10-2-902. Definitions. As used in this part 9, unless the context otherwise requires:

(1) "Controlling person" means any person, firm, association, or corporation that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of the reinsurance intermediary.

(2) "Insurer" means any person, firm, association, or corporation duly licensed in this state pursuant to applicable provisions of the insurance laws as an insurer.

(3) "Licensed producer" means an insurance producer or reinsurance intermediary licensed in this state pursuant to applicable provisions of the insurance laws.

(4) "Reinsurance intermediary" means a reinsurance intermediary-producer as defined in subsection (6) of this section or a reinsurance intermediary-manager as defined in subsection (5) of this section.

(5) "Reinsurance intermediary-manager", or "RM", means any person, firm, association, or corporation that has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer (including the management of a separate division, department, or underwriting office) and acts as an agent for such reinsurer whether known as an RM, manager, or other similar term. Notwithstanding the provisions of this subsection (5), the following persons shall not be considered an RM, with respect to such reinsurer, for the purposes of this part 9:

(a) An employee of the reinsurer;

(b) A United States manager of the United States branch of an alien reinsurer;

(c) An underwriting manager who, pursuant to contract, manages all the reinsurance operations of the reinsurer and who is under common control with the reinsurer subject to the provisions of part 8 of article 3 of this title and whose compensation is not based on the volume of premiums written;

(d) The manager of a group, association, pool, or organization of insurers which engage in joint underwriting or joint reinsurance and are subject to examination by the commissioner or the equivalent insurance regulatory authority of the state in which the manager's principal business office is located.

(6) "Reinsurance intermediary-producer", or "RP", means any person, other than an officer or employee of the ceding insurer, firm, association, or corporation, that solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer.

(7) "Reinsurer" means any person, firm, association, or corporation duly licensed in this state pursuant to the applicable provisions of the insurance laws as an insurer with the authority to assume reinsurance.

(8) "To be in violation" means that the reinsurance intermediary, insurer, or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of this part 9.

Source: L. 93: Entire article R&RE, p. 1374, § 1, effective January 1, 1995. **L. 2009:** (4) to (6) amended, (SB 09-292), ch. 369, p. 1941, § 11, effective August 5. **L. 2025:** IP(5) and (6) amended, (SB 25-300), ch. 428, p. 2439, § 7, effective August 6.

Editor's note: This section is similar to former § 10-2-302 as it existed prior to 1993.

10-2-903. Licensure. (1) No person, firm, association, or corporation shall act as an RP in this state if the RP maintains an office either directly or as a member or employee of a firm or association, or an officer, director, or employee of a corporation:

(a) In this state, unless such RP is a licensed producer in this state; or

(b) In another state, unless such RP is a licensed producer in this state or another state having a law substantially similar to this part 9, or such RP is licensed in this state as a nonresident reinsurance intermediary.

(2) No person, firm, association, or corporation shall act as an RM:

(a) For a reinsurer domiciled in this state, unless such RM is a licensed producer in this state;

(b) In this state, if the RM maintains an office either directly or as a member or employee of a firm or association, or an officer, director, or employee of a corporation in this state, unless such RM is a licensed producer in this state;

(c) In another state for a nondomestic insurer, unless such RM is a licensed producer in this state or another state having a law substantially similar to this part 9 or such person is licensed in this state as a nonresident reinsurance intermediary.

(3) The commissioner may require an RM subject to subsection (2) of this section to:

(a) File a bond in an amount from an insurer acceptable to the commissioner for the protection of the reinsurer; and

(b) Maintain an errors and omissions policy in an amount acceptable to the commissioner.

(4) (a) The commissioner may issue a reinsurance intermediary license to any person, firm, association, or corporation that has complied with the requirements of this part 9. Any such license issued to a firm or association will authorize all the members of such firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and any supplements thereto.

(b) If the applicant for a reinsurance intermediary license is a nonresident, such applicant, as a condition precedent to receiving or holding a license, shall designate the commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this part 9 for designation of service of process upon unauthorized insurers; and also shall furnish the commissioner with the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such nonresident reinsurance intermediary may be served. Such licensee shall promptly notify the commissioner in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the commissioner.

(5) The commissioner may refuse to issue a reinsurance intermediary license if, in the commissioner's judgment, the applicant, any one named on the application, or any member, principal, officer, or director of the applicant, is not trustworthy, or that any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary, or that any individual specified in this subsection (5) has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license. Upon written request therefor, the commissioner shall furnish a summary of the basis for refusal to issue a license, which document shall be privileged and not subject to the provisions of part 2 of article 72 of title 24, C.R.S.

(6) Licensed attorneys at law of this state when acting in their professional capacity as such shall be exempt from this section.

Source: L. 93: Entire article R&RE, p. 1375, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-303 as it existed prior to 1993.

10-2-904. Required contract provisions - reinsurance intermediary-producers. (1) Transactions between an RP and the insurer such RP represents shall only be entered into pursuant to a written authorization specifying the responsibilities of each party. The authorization shall, at a minimum, contain provisions that:

(a) The insurer may terminate the RP's authority at any time;

(b) The RP shall render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the RP, and remit all funds due to the insurer within thirty days of receipt;

(c) All funds collected for the insurer's account shall be held by the RP in a fiduciary capacity in a bank which is a qualified United States financial institution;

(d) The RP shall comply with section 10-2-905;

(e) The RP shall comply with the written standards established by the insurer for the cession or retrocession of all risks;

(f) The RP shall disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

Source: L. 93: Entire article R&RE, p. 1377, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-304 as it existed prior to 1993.

10-2-905. Books and records - reinsurance intermediary-producers. (1) For at least ten years after expiration of each contract of reinsurance transacted by the RP, the RP shall keep a complete record for each transaction showing:

(a) The type of contract, limits, underwriting restrictions, classes, or risks and territory;

(b) The period of coverage, including effective and expiration dates, cancellation provisions, and notice required of cancellation;

(c) The reporting and settlement requirements of balances;

(d) The rate used to compute the reinsurance premium;

(e) The names and addresses of assuming reinsurers;

(f) The rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RP;

(g) Related correspondence and memoranda;

(h) Proof of placement;

(i) Details regarding retrocessions handled by the RP including the identity of retrocessionaires and the percentage of each contract assumed or ceded;

(j) Financial records, including but not limited to premium and loss accounts; and

(k) When the RP procures a reinsurance contract on behalf of a licensed ceding insurer:

(I) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(II) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

(2) The insurer shall have access and the right to copy and audit all accounts and records maintained by the RP related to its business in a form usable by the insurer.

Source: L. 93: Entire article R&RE, p. 1377, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-305 as it existed prior to 1993.

10-2-906. Duties of insurers utilizing the services of a reinsurance intermediary-producer. (1) An insurer shall not engage the services of any person, firm, association, or corporation to act as an RP on its behalf unless such person is licensed as required by section 10-2-903 (1).

(2) An insurer may not employ an individual who is employed by an RP with which it transacts business, unless such RP is under common control with the insurer and subject to the provisions of part 8 of article 3 of this title.

(3) The insurer shall annually obtain a copy of statements of the financial condition of each RP with which it transacts business.

Source: L. 93: Entire article R&RE, p. 1378, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-306 as it existed prior to 1993.

10-2-907. Required contract provisions - reinsurance intermediary-managers. (1) Transactions between an RM and the reinsurer such RM represents shall only be entered into pursuant to a written contract specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least thirty days before such reinsurer assumes or cedes business through such producer, a true copy of the approved contract shall be filed with the commissioner for approval. The contract shall, at a minimum, contain provisions that incorporate all of the following:

(a) The reinsurer may terminate the contract for cause upon written notice to the RM. The reinsurer may suspend the authority of the RM to assume or cede business during the pendency of any dispute regarding the cause for termination.

(b) The RM shall render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the RM, and remit all funds due under the contract to the reinsurer on not less than a monthly basis;

(c) All funds collected for the reinsurer's account shall be held by the RM in a fiduciary capacity in a bank that is a qualified United States financial institution as defined in section 10-1-102 (17). The RM may retain no more than three months' estimated claims payments and allocated loss adjustment expenses. The RM shall maintain a separate bank account for each reinsurer that such RM represents.

(d) For at least ten years after expiration of each contract of reinsurance transacted by the RM, the RM shall keep a complete record for each transaction showing:

(I) The type of contract, limits, underwriting restrictions, classes, or risks and territory;

(II) The period of coverage, including effective and expiration dates, cancellation provisions, notice required for cancellation, and disposition of outstanding reserves on covered risks;

(III) The reporting and settlement requirements of balances;

(IV) The rate used to compute the reinsurance premium;

(V) The names and addresses of reinsurers;

(VI) The rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RM;

(VII) Related correspondence and memoranda;

(VIII) Proof of placement;

(IX) Details regarding retrocessions handled by the RM, as permitted by section 10-2-909 (4), including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(X) Financial records, including but not limited to premium and loss accounts; and

(XI) When the RM places a reinsurance contract on behalf of a ceding insurer:

(A) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(B) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative;

(e) The reinsurer shall have access and the right to copy all accounts and records maintained by the RM related to such RM's business in a form usable by the reinsurer;

(f) The contract cannot be assigned in whole or in part by the RM;

(g) The RM shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks;

(h) The contract sets forth the rates, terms, and purposes of commissions, charges, and other fees which the RM may levy against the reinsurer;

(i) (I) If the contract permits the RM to settle claims on behalf of the reinsurer, all claims shall be reported to the reinsurer in a timely manner.

(II) A copy of the claim file shall be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(A) Has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(B) Involves a coverage dispute;

(C) May exceed the RM claims settlement authority;

(D) Is open for more than six months; or

(E) Is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer;

(III) All claim files shall be the joint property of the reinsurer and RM; however, upon an order of liquidation of the reinsurer, such files shall become the sole property of the reinsurer or its estate; the RM shall have reasonable access to and the right to copy the files on a timely basis;

(IV) Any settlement authority granted to the RM may be terminated for cause upon the reinsurer's written notice to the RM or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(j) If the contract provides for a sharing of interim profits by the RM, that such interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business or a later period set by the commissioner for specified lines of insurance and not until the adequacy of reserves on remaining claims has been verified pursuant to section 10-2-909 (3);

(k) The RM shall annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant;

(l) The reinsurer shall periodically and at least semiannually conduct an on-site review of the underwriting and claims processing operations of the RM;

(m) The RM shall disclose to the reinsurer any relationship such RM has with any insurer prior to ceding or assuming any business with such insurer pursuant to the contract;

(n) The acts of the RM shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

Source: L. 93: Entire article R&RE, p. 1378, § 1, effective January 1, 1995. **L. 2003:** (1)(c) amended, p. 615, § 7, effective July 1.

Editor's note: This section is similar to former § 10-2-307 as it existed prior to 1993.

10-2-908. Prohibited acts. (1) The RM shall not:

(a) Bind retrocessions on behalf of the reinsurer; except that the RM may bind facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsurers with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(b) Commit the reinsurer to participate in reinsurance syndicates;

(c) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed;

(d) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year;

(e) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report shall be promptly forwarded to the reinsurer.

(f) Jointly employ an individual who is employed by the reinsurer;

(g) Appoint a sub-RM.

Source: L. 93: Entire article R&RE, p. 1381, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-308 as it existed prior to 1993.

10-2-909. Duties of reinsurers utilizing the services of a reinsurance intermediary-manager. (1) A reinsurer shall not engage the services of any person, firm, association, or corporation to act as an RM on its behalf unless such person is licensed as required by section 10-2-903 (2).

(2) The reinsurer shall annually obtain a copy of statements of the financial condition of each RM which such reinsurer has engaged prepared by an independent certified accountant in a form acceptable to the commissioner.

(3) If an RM establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the RM. This opinion shall be in addition to any other required loss reserve certification.

(4) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the RM.

(5) Within thirty days of termination of a contract with an RM, the reinsurer shall provide written notification of such termination to the commissioner.

(6) A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder, or subproducer of its RM. This subsection (6) shall not apply to relationships governed by part 8 of article 3 of this title.

Source: L. 93: Entire article R&RE, p. 1382, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-309 as it existed prior to 1993.

10-2-910. Examination authority. (1) A reinsurance intermediary shall be subject to examination by the commissioner. The commissioner shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the commissioner.

(2) An RM may be examined as if it were the reinsurer.

Source: L. 93: Entire article R&RE, p. 1382, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-310 as it existed prior to 1993.

10-2-911. Penalties and liabilities. (1) A reinsurance intermediary, insurer, or reinsurer found by the commissioner, after a hearing conducted in accordance with article 4 of title 24, C.R.S., to be in violation of any provision of this part 9 shall:

(a) For each separate violation, pay a penalty in an amount not to exceed five thousand dollars;

(b) Be subject to revocation or suspension of its license; and

(c) If a violation was committed by the reinsurance intermediary, such reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation.

(2) The decision, determination, or order of the commissioner pursuant to subsection (1) of this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

(3) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided in this title.

(4) Nothing contained in this part 9 is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any rights to such persons.

Source: L. 93: Entire article R&RE, p. 1382, § 1, effective January 1, 1995.

Editor's note: (1) This section is similar to former § 10-2-311 as it existed prior to 1993.

(2) In 2006, the provisions within subsection (1) were relettered to return the subsection to its original form as adopted in House Bill 93-1270.

10-2-912. Rules and regulations. The commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this part 9.

Source: L. 93: Entire article R&RE, p. 1382, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-312 as it existed prior to 1993.

PART 10

MANAGING GENERAL AGENTS ACT

10-2-1001. Short title. This part 10 shall be known and may be cited as the "Managing General Agents Act".

Source: L. 93: Entire article R&RE, p. 1383, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-401 as it existed prior to 1993.

10-2-1002. Definitions. As used in this part 10, unless the context otherwise requires:

(1) "Insurer" means any person, firm, association, or corporation duly licensed in this state as an insurance company pursuant to the applicable provisions of the insurance laws.

(2) (a) "Managing general agent", or "MGA", means any person, firm, association, or corporation who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office, and acts as an agent for such insurer whether known as a managing general agent, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or both of the following:

(I) Adjusts or pays claims in excess of an amount determined by the commissioner; or

(II) Negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding the provisions of paragraph (a) of this subsection (2), the following persons shall not be considered an MGA for the purposes of this part 10:

(I) An employee of the insurer;

(II) A United States manager of the United States branch of an alien insurer;

(III) An underwriting manager who, pursuant to contract, manages all the insurance operations of the insurer and who is under common control with the insurer subject to the provisions of part 8 of article 3 of this title and whose compensation is not based on the volume of premiums written;

(IV) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney.

(3) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

Source: L. 93: Entire article R&RE, p. 1383, § 1, effective January 1, 1995. **L. 2025:** IP(2)(a) amended, (SB 25-300), ch. 428, p. 2440, § 8, effective August 6.

Editor's note: This section is similar to former § 10-2-402 as it existed prior to 1993.

10-2-1003. Licensure. (1) No person, firm, association, or corporation shall act in the capacity of an MGA with respect to risks located in this state for an insurer licensed in this state unless such person is a licensed producer in this state.

(2) No person, firm, association, or corporation shall act in the capacity of an MGA representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as a producer in this state (such license may be a nonresident license) pursuant to the provisions of this part 10.

(3) The commissioner may require a bond in an amount acceptable to the commissioner for the protection of the insurer.

(4) The commissioner may require the MGA to maintain an errors and omissions policy.

Source: L. 93: Entire article R&RE, p. 1384, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-403 as it existed prior to 1993.

10-2-1004. Required contract provisions. (1) No person, firm, association, or corporation acting in the capacity of an MGA shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function, which specifies the division of such responsibilities, and which contains the following minimum provisions:

(a) The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

(b) The MGA shall render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(c) All funds collected for the insurer's account shall be held by the MGA in a fiduciary capacity in a bank which is a member of the federal reserve system. This account shall be used for all payments on behalf of the insurer. The MGA may retain no more than three months' estimated claims payments and allocated loss adjustment expenses.

(d) Separate records of business written by the MGA shall be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer, and the commissioner shall have access to all books, bank accounts, and records of the MGA in a form usable to the commissioner. Such records shall be retained for a period of five years commencing no later than the effective date of the last financial examination of the insurer.

(e) The contract may not be assigned in whole or part by the MGA.

(f) (I) Appropriate underwriting guidelines which shall include:

(A) The maximum annual premium volume;

(B) The basis of the rates to be charged;

(C) The types of risks which may be written;

(D) Maximum limits of liability;

(E) Applicable exclusions;

(F) Territorial limitations;

(G) Policy cancellation provisions; and

(H) The maximum policy period.

(II) The insurer shall have the right to cancel or nonrenew any policy of insurance subject to the applicable laws and regulations concerning the cancellation and nonrenewal of insurance policies.

(g) (I) If the contract permits the MGA to settle claims on behalf of the insurer, all claims shall be reported to the company in a timely manner.

(II) A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim:

(A) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less;

(B) Involves a coverage dispute;

(C) May exceed the MGA's claims settlement authority;

(D) Is open for more than six months; or

(E) Is closed by payment of an amount set by the commissioner or an amount set by the company, whichever is less.

(III) All claim files shall be the joint property of the insurer and the MGA; however, upon an order of liquidation of the insurer, such files shall become the sole property of the insurer or its estate. The MGA shall have reasonable access to and the right to copy the files on a timely basis.

(IV) Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(h) Where electronic claims files are in existence, the contract must address the timely transmission of the data;

(i) If the contract provides for a sharing of interim profits by the MGA, and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits shall not be paid to the MGA until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to section 10-2-1005.

(2) The MGA shall not:

(a) Bind reinsurance or retrocessions on behalf of the insurer; except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(b) Commit the insurer to participate in insurance or reinsurance syndicates;

(c) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which such producer is appointed;

(d) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(e) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer.

(f) Permit its subproducer to serve on the insurer's board of directors;

(g) Jointly employ an individual who is employed with the insurer;

(h) Appoint a sub-MGA.

Source: L. 93: Entire article R&RE, p. 1384, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-404 as it existed prior to 1993.

10-2-1005. Duties of insurers. (1) The insurer shall have on file an independent financial examination, in a form acceptable to the commissioner, of each MGA with which it has done business.

(2) If an MGA establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This is in addition to any other required loss reserve certification.

(3) The insurer shall periodically and at least semiannually conduct an on-site review of the underwriting and claims processing operations of the MGA.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the MGA.

(5) Within thirty days of entering into or termination of a contract with an MGA, the insurer shall provide written notification of such appointment or termination to the commissioner. Notices of appointment of an MGA shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the commissioner may request.

(6) An insurer shall review its books and records each quarter to determine if any producer has become an MGA as defined in section 10-2-1002 (2). If the insurer determines that a producer has become an MGA pursuant to section 10-2-1002 (2), the insurer shall promptly notify the producer and the commissioner of such determination and the insurer and producer shall fully comply with the provisions of this part 10 within thirty days.

(7) An insurer shall not appoint to its board of directors an officer, director, employee, subproducer, or controlling shareholder of its MGA's. This subsection (7) shall not apply to relationships governed by part 8 of article 3 of this title.

Source: L. 93: Entire article R&RE, p. 1387, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-405 as it existed prior to 1993.

10-2-1006. Examination authority. The acts of the MGA are considered to be the acts of the insurer on whose behalf the MGA is acting. An MGA may be examined as if said MGA were the insurer.

Source: L. 93: Entire article R&RE, p. 1388, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-406 as it existed prior to 1993.

10-2-1007. Penalties and liabilities. (1) If the commissioner finds, after a hearing conducted in accordance with article 4 of title 24, C.R.S., that any person has violated any provision of this part 10, the commissioner may order:

(a) For each separate violation, a penalty in an amount not to exceed five thousand dollars;

(b) Revocation or suspension of the producer's license; and

(c) The MGA to reimburse the insurer, the rehabilitator, or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this part 10 committed by the MGA.

(2) The decision, determination, or order of the commissioner pursuant to subsection (1) of this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

(3) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in this title.

(4) Nothing contained in this part 10 is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors.

Source: L. 93: Entire article R&RE, p. 1388, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-407 as it existed prior to 1993.

10-2-1008. Rules and regulations. The commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this part 10.

Source: L. 93: Entire article R&RE, p. 1388, § 1, effective January 1, 1995.

Editor's note: This section is similar to former § 10-2-408 as it existed prior to 1993.

PART 11

EFFECTIVE DATE - APPLICABILITY

10-2-1101. Effective date - applicability. This article shall take effect January 1, 1995. Insurance agent and broker licenses issued pursuant to part 2 of this article prior to said date shall expire at such time as the commissioner shall determine by rule promulgated under the authority of this article. The holders of such licenses may obtain comparable licenses under this article by complying with the rules promulgated by the commissioner under the authority of this article.

Source: L. 93: Entire article R&RE, p. 1389, § 1, effective January 1, 1995.

ARTICLE 3

Regulation of Insurance Companies

PART 1

GENERAL

10-3-101. Formation of insurance companies. (1) Whenever any number of persons associate to form an insurance company for any of the purposes named in section 10-3-102, they shall submit articles of incorporation to the commissioner and attorney general for examination. After being approved by the commissioner and the attorney general, the articles shall be filed in the office of the secretary of state, who shall issue a certificate of incorporation. A copy of such articles, certified by the secretary of state, shall be filed with the commissioner. Any filings made pursuant to this subsection (1) may be in an electronic format.

(2) When not less than the amount required by section 10-3-201 has been paid in by the incorporators and deposited with the commissioner, as provided for in this title (except article 15) and article 14 of title 24, C.R.S., the commissioner shall cause an examination to be made either by the commissioner or some disinterested person especially appointed by the commissioner for the purpose, who shall certify that said provisions have been complied with by said company, as far as applicable thereto. Such certificate shall be filed in the office of the commissioner, who shall thereupon deliver to such company a certified copy thereof, which, together with a copy of the articles of incorporation, shall be filed in the office of the recorder of deeds of the county wherein the company is to be located, before the authority to commence business is granted. Any filings required to be made with the commissioner pursuant to this subsection (2) may be in an electronic format.

(3) Whenever any such corporation thereafter desires to amend its articles of incorporation, it shall file its certificate of amendment with the commissioner before filing the same with the secretary of state, and if the commissioner, with the advice of the attorney general, finds the same to be legally adopted and in due legal form and not in conflict with the provisions of law governing such companies, then and not otherwise such certificate of amendment shall be filed with the secretary of state. Filings required pursuant to this subsection (3) may be in an electronic format.

(4) To supplement the examination powers of the commissioner, as provided in this article, the commissioner may request or require a company, entity, or applicant, or the company, entity, or applicant may make a request to the commissioner, to be examined by independent examiners certified by the society of financial examiners, actuaries who are members of the American academy of actuaries, or other qualified loss reserve specialists, independent risk managers, independent certified public accountants, or other qualified examiners of insurance companies deemed competent by the commissioner, or any combination of such qualified persons. The commissioner may also accept as part of his examination reports made by any qualified person pursuant to this subsection (4). Neither such persons nor members of their immediate families shall be officers of, connected with, or financially interested in the entity, company, or applicant being examined other than as policyholders, nor shall they be

financially interested in any other corporation or person affected by the examination, investigation, or hearing. The commissioner shall establish guidelines for assuring the neutrality of those persons to be authorized to supplement the examination procedures authorized in this article. The reasonable expenses and charges of such persons so retained or designated shall be paid directly by the company, entity, or applicant to any such outside authorized examiner.

Source: L. 13: p. 345, § 30. **L. 15:** p. 269, § 1. **L. 21:** p. 455, § 4. **C.L.** § 2501. **CSA:** C. 87, § 28. **L. 41:** p. 501, § 1. **CRS 53:** § 72-1-42. **C.R.S. 1963:** § 72-1-42. **L. 89:** (4) added, p. 432, § 2, effective June 7. **L. 91:** (4) amended, p. 1242, § 3, effective July 1. **L. 92:** (2) amended, p. 1535, § 22, effective May 20. **L. 2004:** (1), (2), and (3) amended, p. 1058, § 3, effective July 1. **L. 2012:** (2) amended, (HB 12-1266), ch. 280, p. 1501, § 18, effective July 1.

Cross references: For the necessity of certificate of authority to do insurance business, see § 10-3-105.

10-3-102. Purpose of organization or admittance. (1) Any domestic insurance company having the required amount of capital or guaranty fund and surplus, when permitted by its articles of incorporation or charter, may be authorized and licensed by the commissioner to make insurance under one of the following paragraphs:

(a) To make insurance or reinsurance on dwelling houses, stores, and all kinds of buildings and household furniture, and other property against loss or damage, including loss of use or occupancy, by fire, lightning, windstorm, tornado, cyclone, earthquake, hail, bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, and by explosion whether fire ensues or not; also against loss or damage by water or other fluid to any goods or premises arising from the breakage or leakage of sprinklers, pumps, or other apparatus erected for extinguishing fires or of other conduits or containers or by waters entering through leaks or openings in buildings and of water pipes, and against accidental injury to such sprinklers, pumps, apparatus, conduits, containers, or water pipes, and upon vessels, boats, cargoes, goods, merchandise, freights, and other property against loss or damage by any of the risks of lake, river, canal, inland, and ocean navigation and transportation, including all personal property floater risks and including insurance upon automobiles and all types of aircraft, whether stationary or being operated under their own power, which include all of the hazards of fire, explosion, transportation, collision, loss by legal liability for damage to persons and to property resulting from the maintenance and use of automobiles, and airplanes, seaplanes, dirigibles, or other aircraft, and loss by burglary or theft, vandalism, or malicious mischief, or the wrongful conversion, disposal, or concealment of automobiles, and all types of aircraft, whether held under conditional sale contract or subject to chattel mortgages or any one or more of such hazards;

(b) To make insurance or reinsurance upon the lives of persons, and every insurance pertaining thereto or connected therewith, including health and accident insurance, and to grant, purchase, or dispose of annuities, group annuities, unallocated annuities, guaranteed investment contracts, and funding agreement contracts;

(c) To make any of the following kinds of insurance, or reinsurance:

(I) Upon the health of persons;

(II) Against injury, disablement, or death of persons, resulting from traveling or from accidents by land or water;

(III) Upon the lives of horses, cattle, and other livestock;

(IV) Upon plate glass against breakage;

(V) Upon steam boilers, flywheels, and other forms of liability insurance, against explosion and against loss by damage to life or property resulting therefrom;

(VI) Against loss by burglary or theft or both;

(VII) To engage in the business of suretyship, and guaranteeing the fidelity of persons holding places of trust, public or private;

(VIII) Full coverage for motor vehicles;

(IX) All forms of casualty insurance, including all personal property floater risks;

(d) To make insurance or reinsurance upon any of the risks set forth in paragraphs (a) and (c) of this subsection (1);

(e) To make title insurance or reinsurance.

(2) Any foreign or alien insurance company having the required amount of capital or guaranty fund, surplus, and deposit, when permitted by its articles of incorporation or charter and by the proper insurance supervisory authority of its domiciliary jurisdiction, may be authorized and licensed by the commissioner to make insurance under any one of the subsections of this section if otherwise qualified according to law.

(3) No foreign, alien, or domestic insurance company, excluding life insurance companies and title insurance companies, shall expose itself to loss in an amount exceeding ten percent of its paid-up capital or guaranty fund and surplus on any one risk or hazard, unless the same is reinsured through an insurance company which is licensed or accredited in this state, or otherwise through an insurance company acceptable to the commissioner.

(4) Any insurance company authorized to transact the business of title insurance under section 72-1-41 (4)(i), C.R.S. 1963, prior to July 1, 1969, shall not, by reason of the provisions of this part 1, be prohibited from transacting said business.

Source: L. 13: p. 344, § 29. **C.L.** § 2500. **CSA:** C. 87, § 27. **L. 47:** p. 597, § 1. **L. 51:** p. 481, § 1. **CRS 53:** § 72-1-41. **L. 57:** p. 458, § 1. **C.R.S. 1963:** § 72-1-41. **L. 69:** p. 527, §§ 3, 4. **L. 92:** (3) amended, p. 1423, § 3, effective July 1. **L. 2000:** (1)(b) amended, p. 1729, § 1, effective August 15.

Cross references: For the nonapplicability of subsection (3) to pure captive insurance companies, see § 10-6-130 (1).

10-3-103. Names of companies. No domestic insurance company shall adopt the name of any existing company transacting a similar business nor any name so similar as to be calculated to mislead the public, but any domestic mutual or mutual assessment insurance company, upon complying with the terms and conditions of this title (except article 15), and article 14 of title 24, C.R.S., may be reorganized and reincorporated as a joint stock company under the same name by which it was incorporated as a mutual or assessment company, with the omission of the word "mutual", and it is unlawful for any other company to be incorporated or transact business under or by the name under which any such mutual or mutual assessment company was operating at the time of reincorporation.

Source: L. 13: p. 334, § 19. **C.L.** § 2489. **CSA:** C. 87, § 17. **CRS 53:** § 72-1-15. **C.R.S. 1963:** § 72-1-15. **L. 92:** Entire section amended, p. 1535, § 23, effective May 20. **L. 2004:** Entire section amended, p. 898, § 9, effective May 21. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1501, § 19, effective July 1.

10-3-104. Unauthorized companies - penalties. Except for reinsurance by an authorized insurer or insurance effected pursuant to the provisions of article 5 or article 15 of this title 10, it is unlawful for any person, company, or corporation in this state to procure, receive, or forward applications for insurance in, or to issue or to deliver policies for, any company not legally authorized to do business in this state, as provided in this title 10 and article 14 of title 24. Any person violating the provisions of this section commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501.

Source: L. 13: p. 334, § 20. **C.L.** § 2490. **CSA:** C. 87, § 18. **L. 49:** p. 472, § 17. **CRS 53:** § 72-1-16. **C.R.S. 1963:** § 72-1-16. **L. 92:** Entire section amended, p. 1536, § 24, effective May 20. **L. 2003:** Entire section amended, p. 849, § 1, effective July 1. **L. 2006:** Entire section amended, p. 1490, § 9, effective June 1. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1502, § 20, effective July 1. **L. 2021:** Entire section amended, (SB 21-271), ch. 462, p. 3147, § 110, effective March 1, 2022.

10-3-105. Certificate of authority to do business - companies prohibited - definitions. (1) Except pursuant to the provisions of article 5 of this title, no foreign or domestic insurance company shall transact any insurance business in this state, unless it first procures from the commissioner a certificate of authority stating that the requirements of the laws of this state have been complied with and authorizing it to do business. The certificate of authority shall expire on June 30 each year and shall be renewed annually if the company has continued to comply with the laws of the state.

(2) Except as provided by subsection (3) of this section, no certificate of authority to transact any kind of insurance business in this state shall be issued or renewed to any company which is owned, or financially controlled in whole or in part, by another state of the United States, or by a foreign government, or by any political subdivision, instrumentality, or agency of either, unless such company was so owned, controlled, or constituted prior to January 1, 1955, and also authorized to do business in this state on or prior to January 1, 1955.

(3) (a) The ownership or financial control, in part, of any insurer by any state of the United States, or by a foreign government, or by any political subdivision, instrumentality, or agency of either shall not restrict the commissioner from issuing, renewing, or continuing in effect the license of that insurer to transact in this state the kinds of insurance business for which that insurer is otherwise qualified under the provisions of this title and under its charter, if the insurer has satisfied the commissioner that:

(I) It is not subject to any form of subsidy;

(II) It does not engage in practices that discriminate in violation of section 24-34-402, C.R.S.;

(III) The ownership or financial control will not create the presence of any sovereign immunity in the insurer;

(IV) Appropriate measures and controls exist to avoid security problems resulting from the insurer's access to confidential information and data of its insured; and

(V) The ownership or financial control will not result in substantial or undue influence being asserted over the insurer.

(b) The provisions of paragraph (a) of this subsection (3) are a clarification of the provisions of subsection (2) of this section and not a substantive change in the provisions of said subsection (2) as said subsection (2) existed prior to March 11, 1991.

(4) (a) The commissioner may order an insurer to pay restitution to a person, if, after notice to the insurer and after a hearing held in accordance with sections 24-4-104 and 24-4-105, C.R.S., the commissioner finds that the insurer has violated this title or that the insurer is financially responsible for the unfair business practices of an insurance producer pursuant to section 10-3-131.

(b) As used in this subsection (4), "insurance producer" shall have the same meaning as set forth in section 10-2-103 (6).

(c) For the purposes of this subsection (4), "restitution" means benefits or moneys owed due to the regulated entity's violation of this title, including, but not limited to, costs and expenses for lost time from work and attorney fees.

Source: L. 13: p. 334, § 21(1). **C.L.** § 2491. **CSA:** C. 87, § 19. **L. 49:** p. 472, § 18. **CRS 53:** § 72-1-17. **C.R.S. 1963:** § 72-1-17. **L. 91:** (2) amended and (3) added, p. 1239, § 1, effective March 11. **L. 92:** (1) amended, p. 1536, § 25, effective July 1. **L. 2008:** (4) added, p. 585, § 2, effective August 5; (4)(c) amended, p. 2174, § 6, effective August 5.

Cross references: For acts which constitute transacting business by an unauthorized insurer, see § 10-3-903.

10-3-106. Deemed incorporated under corporation law. All insurance companies having capital stock, incorporated under the laws of this state, are deemed to be incorporated under the general corporation laws of this state; but, excepting any provision of existing insurance laws which may purport to prescribe the law under which insurance companies may be or have been incorporated, no law or provision of law specially or expressly applicable to insurance companies or the business of insurance shall be in any way repealed, modified, or affected by this section.

Source: L. 33: p. 615, § 3. **CSA:** C. 87, § 53. **CRS 53:** § 72-1-51. **C.R.S. 1963:** § 72-1-51.

Cross references: For the general corporation law, see articles 101 to 117 of title 7.

10-3-107. Appointment of registered agent to receive service of process - commissioner required to maintain list - when service of process may be made on commissioner. (1) (a) An insurance company shall not engage in the business of insurance in this state unless it has filed with the commissioner the name of a registered agent in this state designated to receive service of process.

(b) The commissioner shall maintain a list of registered agents that are designated to receive service of process pursuant to subsection (1)(a) of this section and shall make information from the list available to any person upon request. Each insurance company must report any change in the registered agent designated to receive service of process to the commissioner within ten days after making the change.

(c) The information required to be filed with the commissioner pursuant to this subsection (1) may be filed in an electronic format.

(2) Notwithstanding subsection (1) of this section, service of process may be made on the commissioner if:

(a) An insurance company fails to appoint or maintain a registered agent as required by subsection (1) of this section;

(b) An insurance company's registered agent under subsection (1) of this section cannot be found with reasonable diligence; or

(c) An insurance company's certificate of authority is revoked.

(3) If an individual reasonably relies on the list of registered agents maintained by the commissioner pursuant to subsection (1)(b) of this section and serves otherwise valid process on an insurance company's registered agent so designated in the list, and it is later determined that the registered agent listed by the commissioner is not the correct registered agent properly designated by the company, then:

(a) The individual may serve process upon the commissioner; and

(b) If the individual uses due diligence to serve the commissioner, the applicable statute of limitations is tolled for the period of time beginning when the incorrect registered agent received service of process and ending when the commissioner receives service of process.

(4) Whenever lawful process against any insurance company is served upon the commissioner, three copies shall be furnished, and the commissioner shall forward a copy of the process to the secretary of the company or, in case of companies of foreign countries, to the resident manager in this country, and the commissioner shall also forward a copy of the process to the general agent of said company in this state.

Source: L. 13: p. 339, § 22. **C.L.** § 2492. **CSA:** C. 87, § 20. **L. 49:** p. 473, § 19. **CRS 53:** § 72-1-33. **C.R.S. 1963:** § 72-1-33. **L. 73:** p. 847, § 1. **L. 86:** (2) amended, p. 554, § 2, effective July 1. **L. 89:** (2) amended, p. 436, § 4, effective July 1. **L. 91:** (2) amended, p. 1228, § 2, effective June 5; (1.5) added, p. 1243, § 4, effective July 1. **L. 2004:** (1) and (1.5)(b) amended, p. 1059, § 4, effective July 1. **L. 2022:** Entire section amended, (HB 22-1398), ch. 270, p. 1949, § 1, effective August 10.

10-3-108. File duly certified copy of charter. Except pursuant to the provisions of article 5 of this title, no foreign insurance company shall transact any business in this state unless it first files in the office of the commissioner a duly certified copy of its charter, articles of incorporation, or deed of settlement, together with a statement, under oath, of the president and secretary, or other chief officers of such company, showing the condition of affairs of such company on the thirty-first day of December next preceding the date of such oath. The statement shall be in the same form and shall set forth the same particulars as the annual statement required by this title (except article 15) and article 14 of title 24, C.R.S. After filing its articles of incorporation or charter with the secretary of state, no insurance company shall be required to

file its annual report or any other instrument, except amendments to said articles of incorporation or charter, in the office of the secretary of state or to pay to the secretary of state an annual corporation tax. The filings required pursuant to this section may be made in an electronic format.

Source: L. 13: p. 339, § 23. **C.L.** § 2493. **CSA:** C. 87, § 21. **L. 49:** p. 473, § 20. **CRS 53:** § 72-1-34. **C.R.S. 1963:** § 72-1-34. **L. 92:** Entire section amended, p. 1536, § 26, effective May 20. **L. 2004:** Entire section amended, p. 1060, § 5, effective July 1. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1502, § 21, effective July 1.

10-3-109. Reports, statements, assessments, and maintenance of records - publication - penalties for late filing, late payment, or failure to maintain. (1) Every insurance company doing business in this state, on or before the first day of March in each year, shall submit to the commissioner a report, signed and certified by its chief officers, of its condition on the preceding thirty-first day of December, which shall include a detailed statement of assets and liabilities, the amount and character of its business transacted, and moneys received and expended during the year, and any further details of expenditures, and such other information, to be included in the report or supplementary thereto, as the commissioner deems necessary. A synopsis of such statement, together with the commissioner's certificate of authority to transact business in this state, shall be published in some newspaper of general circulation, published at the state capital, for at least four insertions. Such publication shall be made within thirty days after such certificate of authority is issued, and a copy of the paper containing such publication shall be filed in the office of the commissioner. The commissioner shall revoke and refuse to reissue the certificate of authority of any insurance company failing or refusing to furnish the reports or other information requested by the commissioner as provided in this section. The report required pursuant to this subsection (1) may be filed in an electronic format.

(2) Repealed.

(3) If any entity regulated by the division of insurance fails to file any other document required by law or rules and regulations to be filed with the division of insurance or fails to maintain complaint records as required by law, the commissioner may assess a penalty not to exceed five hundred dollars for an initial violation and a penalty not to exceed five thousand dollars for any subsequent failure to comply with any such filing requirement or requirement to maintain records. The commissioner, by rule and regulation, may establish a schedule for the assessment of penalties as authorized in this subsection (3) based upon the frequency and severity of noncompliance.

Source: L. 13: p. 340, § 24. **C.L.** § 2494. **CSA:** C. 87, § 22. **CRS 53:** § 72-1-35. **C.R.S. 1963:** § 72-1-35. **L. 92:** Entire section amended, p. 1536, § 27, effective May 20. **L. 2001:** (2) amended, p. 1051, § 35, effective July 1. **L. 2004:** (1) amended, p. 1060, § 6, effective July 1. **L. 2013:** (2) amended, (HB 13-1115), ch. 338, p. 1970, § 3, effective May 28.

Editor's note: Subsection (2)(b) provided for the repeal of subsection (2), effective March 31, 2015. (See L. 2013, p. 1970.)

Cross references: For financial statements, see § 10-3-208; for nondisclosure of reports during periods of supervision or conservatorship, see § 10-3-414.

10-3-110. Remuneration of company officials. (Repealed)

Source: L. 13: p. 354, § 52. **C.L.** § 2525. **CSA:** C. 87, § 67. **CRS 53:** § 72-3-14. **C.R.S. 1963:** § 72-3-14. **L. 71:** p. 718, § 1. **L. 81:** Entire section repealed, p. 524, § 1, effective March 27.

10-3-111. Violations - penalty. Except for violations of section 10-3-104 or article 15 of this title 10, any officer, director, stockholder, attorney, or agent of any corporation or association who violates any of the provisions of this title 10 and article 14 of title 24, who participates in or aids, abets, or advises or consents to any such violation, and any person who solicits or knowingly receives any money or property in violation of said references commits a class 2 misdemeanor, and any officer aiding or abetting in any contribution made in violation of said references is liable to the company or association for the amount so contributed. No person shall be excused from attending and testifying or producing any books, papers, or other documents, before any court, upon any investigation, proceeding, or trial, for a violation of any of the provisions of said references upon the ground or for the reason that the testimony or evidence, documentary or otherwise, required of such person may tend to incriminate or degrade him or her; but no person shall be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which he or she may so testify or produce evidence, documentary or otherwise, and no testimony so given or produced shall be used against him or her upon any criminal investigation or proceeding.

Source: L. 13: p. 354, § 53. **C.L.** § 2526. **CSA:** C. 87, § 68. **CRS 53:** § 72-3-15. **C.R.S. 1963:** § 72-3-15. **L. 83:** Entire section amended, p. 448, § 1, effective March 15. **L. 92:** Entire section amended, p. 1537, § 28, effective May 20. **L. 2003:** Entire section amended, p. 849, § 2, effective July 1. **L. 2005:** Entire section amended, p. 761, § 12, effective June 1. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1502, § 22, effective July 1. **L. 2021:** Entire section amended, (SB 21-271), ch. 462, p. 3147, § 111, effective March 1, 2022.

Cross references: For the penalty for a class 2 misdemeanor, see § 18-1.3-501.

10-3-112. Directors - terms - election - conflicts of interest - recovery of profits. (1) (a) The business of insurance companies incorporated under the laws of this state shall be managed by a board of directors consisting of such number of directors, not less than three, as may be prescribed by the articles of incorporation or bylaws, and said directors shall hold office until their successors are duly elected and qualified. Such directors shall be nominated and elected in the manner prescribed by the bylaws of the company not inconsistent with the laws of this state. No director may serve who has been convicted of fraud involving any financial institution or of a felony, but the commissioner may waive this provision regarding a felony if he or she determines that the particular felony does not jeopardize the person's ability to act as a director.

(b) (I) Each executive officer and director of a domestic company applying for a certificate of authority to do business in Colorado shall submit a set of fingerprints to the commissioner. The commissioner shall forward such fingerprints to the Colorado bureau of investigation for the purpose of conducting a state and national fingerprint-based criminal history record check utilizing records of the Colorado bureau of investigation and the federal bureau of investigation. Only the actual costs of such record check must be borne by the employer.

(II) When the results of a fingerprint-based criminal history record check of a person performed pursuant to this subsection (1)(b) reveal a record of arrest without a disposition, the commissioner shall require that person to submit to a name-based judicial record check, as defined in section 22-2-119.3 (6)(d).

(2) Every domestic insurance company shall report within thirty days to the commissioner any change in its executive officers or directors, including in its report a statement of the business and professional affiliations of any new executive officer or director. For purposes of this subsection (2), the term "executive officer" includes only the following: Chairman of the board of directors, president, executive vice-president, secretary, and treasurer.

(3) No director, officer, or employee having any authority in the investment or disposition of the funds of a domestic insurance company shall accept, except on behalf of the company, or be the beneficiary of any fee, brokerage, gift, or other emolument because of any investment, loan, deposit, purchase, sale, payment, or exchange made by or for the company; but a director who is not otherwise an officer or employee of the company may receive reasonable compensation for necessary services performed for sales or purchases made to or for the company in the ordinary course of its business and in the usual private professional or business capacity of such director.

(4) Any profit or gain received by or on behalf of any person in violation of subsection (3) of this section shall inure to and be recoverable by the company. Suit to recover such profit may be instituted in any court of competent jurisdiction by the company, or by any stockholder of the company in its name and in its behalf if the company fails or refuses to bring such suit within sixty days after request in writing or fails diligently to prosecute the same thereafter; but no such suit shall be brought more than two years after the date such profit was realized.

Source: L. 13: p. 346, § 31. **C.L.** § 2502. **L. 33:** p. 614, § 1. **CSA:** C. 87, § 29. **CRS 53:** § 72-1-43. **C.R.S. 1963:** § 72-1-43. **L. 67:** p. 163, § 1. **L. 69:** p. 510, § 1. **L. 2002:** (1) amended, p. 970, § 1, effective June 1. **L. 2019:** (1)(b) amended, (HB 19-1166), ch. 125, p. 537, § 2, effective April 18. **L. 2022:** (1)(b)(II) amended, (HB 22-1270), ch. 114, p. 513, § 3, effective April 21.

10-3-113. Increase of capital. (1) Any such corporation organized and duly licensed by the commissioner to conduct an insurance business may sell additional stock or increase its capital for the purpose, in the manner, and to the extent prescribed by law, but the expense incurred in connection with such sale shall not exceed twenty percent of the amount realized from the sale of its capital stock, whether in cash or notes, and said expense shall be paid from surplus funds of the corporation.

(2) The provisions of this title (except article 15) and article 14 of title 24, C.R.S., also apply in the formation and authorization of domestic insurance companies formed upon the

mutual plan, and to associations formed upon the assessment plan, that are organized with a guaranty fund in lieu of capital as provided in said references.

Source: L. 13: p. 346, § 2. **L. 15:** p. 270, § 1. **L. 21:** p. 457, § 5. **C.L.** § 2503. **CSA:** C. 87, § 30. **L. 41:** p. 502, § 2. **CRS 53:** § 72-1-44. **L. 57:** p. 758, § 9. **C.R.S. 1963:** § 72-1-44. **L. 92:** (2) amended, p. 1538, § 29, effective May 20. **L. 2004:** (2) amended, p. 898, § 10, effective May 21. **L. 2012:** (2) amended, (HB 12-1266), ch. 280, p. 1503, § 23, effective July 1.

10-3-114. Violations - penalty. Any officer, director, clerk, employee, or agent of any such company who receives or pays out, or orders the payment of, any money, or incurs any obligation for the payment of money, in violation of the terms of section 10-3-113 commits a class 2 misdemeanor.

Source: L. 13: p. 346, § 33. **C.L.** § 2504. **CSA:** C. 87, § 31. **CRS 53:** § 72-1-45. **C.R.S. 1963:** § 72-1-45. **L. 2021:** Entire section amended, (SB 21-271), ch. 462, p. 3147, § 112, effective March 1, 2022.

Cross references: For the penalty for a class 2 misdemeanor, see § 18-1.3-501.

10-3-115. License required of foreign companies. (Repealed)

Source: L. 13: p. 347, § 34. **C.L.** § 2505. **CSA:** C. 87, § 32. **CRS 53:** § 72-1-46. **C.R.S. 1963:** § 72-1-46. **L. 92:** Entire section repealed, p. 1538, § 30, effective May 20.

10-3-116. Sale of stock without license - penalty. (Repealed)

Source: L. 13: p. 347, § 35. **C.L.** § 2506. **CSA:** C. 87, § 33. **CRS 53:** § 72-1-47. **C.R.S. 1963:** § 72-1-47. **L. 92:** Entire section repealed, p. 1538, § 31, effective May 20.

10-3-117. License automatically extended - when. When the annual statement of an insurance company licensed to do business in this state has been filed and the company's check or cash for the amount of all fees and taxes required has been tendered, the company's license to do business in this state shall be automatically extended until the commissioner refuses to relicense such company, and, when a check or cash for the fee has been tendered by the company for renewal of an agent's license, the license shall automatically be extended until the commissioner refuses to renew the license.

Source: L. 25: p. 316, § 6. **CSA:** C. 87, § 47. **CRS 53:** § 72-2-7. **C.R.S. 1963:** § 72-2-6.

Cross references: For statements generally, see § 10-3-109; for financial statements, see § 10-3-208.

10-3-118. Reinsurance - conditions - credit for reinsurance. (Repealed)

Source: L. 25: p. 318, § 10. **CSA:** C. 87, § 51. **L. 51:** p. 488, § 1. **CRS 53:** § 72-2-12. **C.R.S. 1963:** § 72-2-10. **L. 71:** p. 707, § 1. **L. 79:** Entire section R&RE, p. 380, § 1, effective May 25. **L. 85:** (7)(a)(IV) added, p. 378, § 1, effective July 1. **L. 86:** (6)(c) and (6)(d) added, p. 554, § 3, effective July 1. **L. 89:** (6)(c) and (6)(d) amended, p. 436, § 5, effective July 1. **L. 91:** (6) amended, p. 1229, § 3, effective June 5. **L. 92:** Entire section amended, p. 1539, § 32, effective May 20. **L. 95:** (5)(d)(I) amended, p. 489, § 2, effective May 16. **L. 2003:** (5)(d)(I), IP(6), and (6)(c) amended, p. 615, § 8, effective July 1. **L. 2005:** Entire section amended, p. 552, § 1, effective August 8. **L. 2014:** Entire section repealed, (HB 14-1315), ch. 295, p. 1217, § 3, effective January 1, 2015.

10-3-119. Application for receivership. (Repealed)

Source: L. 25: p. 319, § 11. **CSA:** C. 87, § 52. **CRS 53:** § 72-2-13. **L. 63:** p. 290, § 8. **C.R.S. 1963:** § 72-2-11. **L. 92:** Entire section repealed, p. 1424, § 4, effective July 1.

10-3-120. Investments of officers, directors, and principal stockholders. (1) (a) Every person who is directly or indirectly the beneficial owner of more than ten percent of any class of equity security of a domestic stock insurance company or who is a director or an officer of such company shall file in the office of the commissioner within ten days after the person becomes such beneficial owner, director, or officer, a statement, in such form as the commissioner may prescribe, of the amount of all classes of equity securities of such company of which the person is the beneficial owner and within ten days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file in the office of the commissioner a statement, in such form as the commissioner may prescribe, indicating ownership at the close of the calendar month and such changes in ownership as have occurred during such calendar month.

(b) (Deleted by amendment, L. 96, p. 111, § 1, effective March 25, 1996.)

(2) For the purpose of preventing the unfair use of information which is obtained by such beneficial owner, director, or officer by reason of his relationship to such company, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such company within any period of less than six months, unless such equity security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director, or officer in entering into such transaction of holding the equity security purchased or of not repurchasing the equity security sold for a period exceeding six months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company or by the owner of any security of the company in the name and in behalf of the company if the company fails or refuses to bring such suit within sixty days after request or fails diligently to prosecute the same thereafter, but no such suit shall be brought more than two years after the date such profit was realized. This subsection (2) shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the equity security involved, or any transaction which the commissioner may by rules and regulations exempt as not comprehended within the purpose of this subsection (2).

(3) It is unlawful for any such beneficial owner, director, or officer, directly or indirectly, to sell any equity security of such company if the person selling the equity security or his principal either does not own the equity security sold, or, if owning the equity security, does not deliver it against such sale within twenty days thereafter, or does not within five days after such sale deposit it in the mails or other usual channels of transportation; but no person is deemed to have violated this subsection (3) if he proves that, notwithstanding the exercise of good faith, he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

(4) The provisions of subsection (2) of this section shall not apply to any purchase and sale or sale and purchase, and the provisions of subsection (3) of this section shall not apply to any sale of an equity security not then or theretofore held by him in an investment account by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market, otherwise than on an exchange, as presently defined in the federal "Securities Exchange Act of 1934", as amended, for such security.

(5) The provisions of this section shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the commissioner may adopt in order to carry out the purposes of this section.

(6) The term "equity security" means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the commissioner deems to be of similar nature and considers necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security.

(7) The provisions of this section shall not apply to equity securities of a domestic stock insurance company if:

(a) Such equity securities are registered, or are required to be registered, pursuant to section 12 of the federal "Securities Exchange Act of 1934", as amended; or

(b) Such domestic stock insurance company does not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of this section, except for the provisions of this paragraph (b).

Source: L. 65: p. 760, § 1. **C.R.S. 1963:** § 72-2-17. **L. 95:** (1) repealed, p. 196, § 7, effective April 13; (1) RC&RE, p. 718, § 1, effective May 23. **L. 96:** (1) amended, p. 111, § 1, effective March 25. **L. 2008:** (4) and (7)(a) amended, p. 1880, § 10, effective August 5.

Cross references: For the "Securities Exchange Act of 1934", see 15 U.S.C. § 78a et seq.

10-3-121. Regulation of proxies, consents, or authorizations. (1) The purpose of this section is to regulate the solicitation of proxies, consents, or authorizations by domestic stock insurers having one hundred or more stockholders of record in accordance with the intent of congress as expressed in the "Securities Acts Amendments of 1964", by declaring unlawful certain solicitation practices and providing for the regulation thereof.

(2) No person shall, in contravention of such rules and regulations as the commissioner may prescribe as necessary or appropriate in the public interest or for the protection of investors, solicit, or permit the use of his name to solicit, any proxy or consent or authorization in respect of any security of a domestic stock insurer having one hundred or more stockholders of record.

(3) Unless proxies, consents, or authorizations in respect of a security of a domestic stock insurer are solicited by or on behalf of the management of the insurer from the holders of record of such security in accordance with the rules and regulations prescribed under subsection (2) of this section, prior to any annual or other meeting of the holders of such security, such insurer shall, in accordance with the rules and regulations prescribed by the commissioner, file with the commissioner and transmit to all holders of record of such security information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

(4) This section is applicable to all domestic stock insurers having one hundred or more stockholders of record; except that this section shall not apply to any insurer if ninety-five percent or more of its stock is owned or controlled by a parent or an affiliated insurer and the remaining shares are held by less than five hundred stockholders. A domestic stock insurer that files with the securities and exchange commission forms of proxies, consents, and authorizations complying with the requirements of the federal "Securities Exchange Act of 1934", as amended, is exempt from the provisions of this section.

(5) The term "person" as used in this section includes a natural person, corporation, partnership, and association.

(6) Repealed.

Source: L. 65: p. 763, § 1. **C.R.S. 1963:** § 72-2-18. **L. 95:** Entire section repealed, p. 196, § 8, effective April 13; entire section RC&RE, p. 718, § 2, effective May 23. **L. 96:** (6) repealed, p. 95, § 2, effective March 25. **L. 2008:** (4) amended, p. 1880, § 11, effective August 5.

Cross references: For the "Securities Acts Amendments of 1964" and the "Securities Exchange Act of 1934", see 15 U.S.C. § 78a et seq.

10-3-122. Duties of foreign companies. Any foreign life or accident insurance company doing business in the state of Colorado, if the insurance contract is made in this state, shall pay its obligations when same are due and payable through its agent in the county where the contract was made, or at the office of its general agent within this state, after approval by the proper officers at the home office of the company, upon presentation of the insurance contract and proofs required thereunder by the insured, assigns, or beneficiaries. This insurance contract is deemed to be made and payable in the state of Colorado, if made through an authorized agent of such insurance company within this state, irrespective of where the insurance contract may be written.

Source: L. 13: p. 357, § 58. **C.L.** § 2531. **CSA:** C. 87, § 75. **CRS 53:** § 72-3-22. **C.R.S. 1963:** § 72-3-22.

Cross references: For life insurance generally, see article 7 of this title 10.

10-3-123. Assessment accident associations. (1) Every contract whereby a benefit is to accrue to a party named therein, upon the accidental death or physical disability from accident or sickness of a person, which benefit is in any degree conditioned upon the collection of an assessment upon persons holding similar contracts, is deemed a contract of accident or casualty insurance upon the assessment plan, and the business involving the issuance of such contract shall be carried on in this state only by duly authorized corporations, which are subject to the provisions and requirements of this section and the general laws governing insurance companies in this state, except as otherwise provided in this section; but nothing in this section shall be construed as applicable to organizations which conduct their business as fraternal societies, on the lodge system, or to organizations which do not employ paid agents in soliciting business or limit their certificate holders to a particular order or fraternity.

(2) Twenty-five or more persons who are citizens of this state may form a corporation to carry on the business of casualty insurance on the assessment plan, but no such corporation shall begin to do business until a guaranty fund of at least ten thousand dollars is provided and deposited, in cash or in such securities as are permitted by law in the case of stock companies, with the commissioner under the conditions named in this title (except article 15) and article 14 of title 24, C.R.S. When this is done and at least two hundred persons have subscribed in writing to be insured, and when each has paid in at least one monthly assessment or premium, the commissioner, if the laws have been complied with, shall issue a certificate of authority for such corporation, which authorizes it to commence business. The word "association" shall be used in the title or name of all corporations organized under this section instead of the word "company".

(3) Every policy or indemnity certificate issued by any casualty corporation doing business in this state shall show, in plain and legible print at the top and on the face of the same, these words: "Incorporated on the assessment plan".

(4) There shall also be printed plainly and legibly in every such policy or certificate issued the minimum and maximum limits of the contingent mutual liability of the person to whom the policy is issued, which limits and the amount of liability, in the case of corporations incorporated under the Colorado laws, shall be fixed by the bylaws, and the rule shall be uniform. Such policies or certificates shall also specify the minimum sum of money to be paid upon each contingency insured against and the number of days after satisfactory proof of the happening of such contingency at which such payment shall be made. Upon the occurrence of such contingency, unless the contract has been voided by fraud or by breach of its conditions, the association is obligated to the beneficiary for such payment at the time and to the amount specified in the policy or certificate, and this indebtedness shall be a lien upon all the property, effects, and bills receivable of the association in this state, with priority over all indebtedness thereafter incurred, but the statement of said minimum sum shall not invalidate the rights of the party insured from receiving any further amount above such minimum sum that is based upon membership and to which he is entitled by the provisions of his policy.

(5) Any corporation organized under the authority of any other state or government to issue policies or certificates of casualty insurance on the assessment plan, as a condition precedent to transacting business in this state, shall pay such fees and comply with the same requirements as exacted of stock casualty insurance companies of other states or countries, as provided by this title (except article 15) and article 14 of title 24, C.R.S., and thereafter be subject to the same general laws and penalties of this title, unless otherwise provided in this section, and it shall deposit with the commissioner or with the proper official of some other state,

for the protection of all its policyholders, a sum not less than that required to be deposited by domestic casualty insurance companies organized upon the mutual assessment plan. Such corporation shall also file with the commissioner a copy of its policies or certificates and applications therefor, for approval by the commissioner, and a sworn statement from the proper officers of such corporation that they have received a copy of this section, and shall be governed thereby in issuing policies or certificates in this state. The commissioner may thereupon issue or renew the authority of such corporation to do business in this state.

(6) The money or other benefit, charity, relief, or aid to be paid or provided or rendered by any corporation authorized to do casualty insurance on the assessment plan shall not be liable to attachment or other process and shall not be seized, taken, appropriated, or applied by any legal or equitable process, nor by operation of law, to pay any debts or liability of a policy or certificate holder, or any beneficiary named therein.

(7) Any corporation doing a casualty insurance business in this state on April 15, 1913, that is incorporated to do business on the assessment plan may reincorporate under the provisions of this title (except article 15) and article 14 of title 24, C.R.S., but nothing in said references shall be construed as requiring any such corporation to reincorporate, and any such corporation may continue to exercise all rights, powers, and privileges conferred by said references, or its articles of incorporation not inconsistent with this subsection (7).

Source: L. 13: p. 369, § 75. **C.L.** § 2548. **CSA:** C. 87, § 92. **CRS 53:** § 72-3-26. **C.R.S. 1963:** § 72-3-25. **L. 92:** (2), (5), and (7) amended, p. 1544, § 33, effective May 20. **L. 2004:** (2), (5), and (7) amended, p. 899, § 11, effective May 21. **L. 2012:** (2), (5), and (7) amended, (HB 12-1266), ch. 280, p. 1503, § 24, effective July 1.

10-3-124. Advertisement for insurance - requirement. (Repealed)

Source: L. 73: p. 836, § 1. **C.R.S. 1963:** § 72-1-65. **L. 77:** Entire section repealed, p. 502, §§ 7, 8, effective January 1, 1978.

10-3-125. Redomestication of foreign insurers. (1) Any foreign insurer which is authorized or which may be authorized to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type. Said domestic insurer shall be entitled to like certificates and licenses to transact business in this state and shall be subject to the authority and jurisdiction of this state.

(2) Any domestic insurer may, upon the approval of the commissioner, transfer its domicile to any other state in which it is authorized to transact the business of insurance and, upon such a transfer, shall cease to be a domestic insurer and shall be admitted to this state if qualified as a foreign insurer. The commissioner shall approve any such proposed transfer unless he determines that such transfer is not in the interest of the policyholders of this state.

(3) Any foreign insurance company admitted or which may be admitted to transact business in this state may, upon proper notice to the commissioner, change its domicile by merger, consolidation, or otherwise to another foreign state without interruption of its license and without reapplying as a foreign insurer if:

(a) The change in domicile does not result in a reduction in the company's assets or surplus below the requirements for admission as a foreign insurer; and

(b) There is no substantial change in the lines of insurance to be written by the company; and

(c) The change in domicile has been approved by the supervising regulatory officials of both the former and new state of domicile.

(4) The certificate of authority, the agents' appointments and licenses, and the rates and other items which the commissioner allows, in his discretion, which are in existence at the time any insurer transfers its corporate domicile to this or any other state by merger, consolidation, or any other lawful method shall continue in full force and effect upon such transfer if such insurer remains duly qualified to transact the business of insurance in this state. All outstanding policies of any transferring insurer shall remain in full force and effect. In the event of a company name change, all outstanding policies shall be endorsed with the company's new name. Every transferring insurer shall file new policy forms with the commissioner on or before the effective date of the transfer. Such insurers may use existing policy forms with appropriate endorsements if allowed by and under such conditions as approved by the commissioner. Every such transferring insurer shall notify the commissioner of the details of the proposed transfer and shall file promptly any resulting amendments to corporate documents filed or required to be filed with the commissioner.

Source: L. 89: Entire section added, p. 443, § 1, effective April 19.

10-3-126. Alien insurers. (1) Any alien insurer, as defined in section 10-3-301 (1), may be admitted to do business in this state by qualifying and establishing an administrative office in this state and maintaining its corporate and insurance records in the United States for insurance of risks primarily in the United States of America, its territories, and its possessions and by complying with all of the requirements of law related to the organization and licensing of a domestic insurer of the same type.

(2) Any alien insurer, as defined in section 10-3-301 (1), which is authorized to do business (whether as an admitted company or nonadmitted company) for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by making its principal place of business at a place in this state. Said domestic insurer shall be entitled to like certificates and licenses to transact business in this state and shall be subject to the authority and jurisdiction of this state.

Source: L. 89: Entire section added, p. 444, § 1, effective April 19.

10-3-127. Domicile of nonprofit hospital, medical-surgical, and health services corporations. (1) A corporation organized under the laws of another state for the purposes set forth in section 10-16-302 may qualify under parts 1 and 3 of article 16 of this title to do business in this state as a nonprofit hospital, medical-surgical, and health services corporation, and upon notice to the commissioner may change its domicile by merger, consolidation, or otherwise under the procedures of section 10-3-125 for insurers. Except as specified in this

section, any such corporation shall comply with all provisions of parts 1 and 3 of article 16 of this title with respect to the business of the corporation in this state.

(2) The provisions of sections 10-16-304 (1) and 10-16-305 (1) shall apply to a foreign corporation to the extent such provisions do not conflict with the governing laws of the corporation's domicile.

Source: L. 89: Entire section added, p. 444, § 1, effective April 19. **L. 92:** Entire section amended, p. 1723, § 3, effective July 1.

10-3-128. Domestic insurer - requirement to maintain offices in this state. (1) Before granting the initial certificate of authority to an applicant to become a domestic insurer, the commissioner shall be satisfied by proper evidence that:

(a) The insurer's books and records are located or maintained in this state or are readily accessible to the examiners of this state; and

(b) The grant of a certificate of authority as a domestic insurer will provide benefit to the state of Colorado through either significant economic development or through the offering of insurance coverage desired by and beneficial to the Colorado insurance buying public.

(2) No later than January 1, 1992, any domestic insurer licensed in this state prior to July 1, 1991, shall file a plan for compliance with this section.

(3) The commissioner may modify or waive the requirements of this section for cause on a case by case basis.

(4) The commissioner may promulgate such rules and regulations as are necessary to carry out the provisions of this section.

Source: L. 91: Entire section added, p. 1243, § 5, effective July 1.

10-3-129. Prohibition - display of social security number - insurance companies. (1) An insured may require that an insurance company or insurer doing business in Colorado not display the insured's social security number on his or her insurance identification card or proof of insurance card. If an insured makes the request, the insurance company or insurer shall reissue the insured an insurance identification card or proof of insurance card that does not display the insured's social security number.

(2) After January 1, 2006, upon issuance or renewal of an insurance policy, an insurance company or insurer doing business in Colorado shall not issue an insurance identification card or proof of insurance card that displays the insured's social security number.

Source: L. 2004: Entire section added, p. 1959, § 4, effective August 4.

10-3-130. Certificate of authority application process - tracking compliance with uniform process. The division shall make every effort to comply with the uniform process established and endorsed by the national association of insurance commissioners for applications for certificates of authority, including compliance with established deadlines for evaluating, approving, and denying applications for certificates of authority. The division shall track all aspects of the certificate of authority application process in order to monitor compliance with the

uniform standards and to enable comparison with other states for purposes of determining areas for improvement.

Source: L. 2006: Entire section added, p. 76, § 2, effective March 27.

10-3-131. Acts of producers - responsibility of insurer - definitions. (1) An insurer authorized to conduct business in this state, who knew or should have known about the unfair business practices of an insurance producer, may be financially responsible for the unfair business practices of the insurance producer, who, while acting on behalf of the insurer, engaged in unfair business practices that violate this title.

(2) As used in this section, "insurance producer" shall have the meaning set forth in section 10-2-103.

Source: L. 2008: Entire section added, p. 586, § 3, effective August 5.

PART 2

FINANCIAL AFFAIRS

10-3-201. Cash capital - guaranty fund - deposit.

(1) (a) (I) to (IV) Repealed.

(V) No insurance company, issued a certificate of authority on or after July 1, 1995, shall be permitted to do any business in this state, unless, in addition to the other requirements of law, it possesses the minimum capital or guaranty fund and an accumulated surplus in the form of cash or marketable securities which combined are at least equal to:

TYPE OF COMPANYTOTAL CAPITAL
OR GUARANTY FUND
PLUS SURPLUS

Life $1,500,000.00
Fire 1,500,000.00
Casualty 1,500,000.00
Multiple Line 2,000,000.00
Title Insurance 750,000.00

(b) To avoid situations where an insurer's transactions would create undue financial risks to its enrollees, subscribers, or policyholders or to the people of this state, the regulations specified in this paragraph (b) are authorized. The commissioner may by regulation establish standards consistent with those of the national association of insurance commissioners which require any insurer to maintain a greater minimum surplus level than the specific dollar minimums established by paragraph (a) of this subsection (1). Such minimum surplus level shall reflect the type, volume, and nature of the insurance business being transacted and the type of entity for which the surplus levels are being established. Such regulation may additionally require the submission of an opinion by a qualified actuary which states whether or not the surplus level of the entity is sufficient for the authority requested.

(c) Companies already licensed on July 1, 1991, may continue to transact business and shall have until December 31, 1992, to increase their total capital or guaranty fund and surplus or file a plan with the commissioner. The commissioner may, upon showing of adequate justification by the company, extend the date for the company to attain the new levels specified in paragraph (a) of this subsection (1), or waive or reduce such new levels.

(d) An insurance company subject to this section shall increase its capital and surplus to those limits set forth in paragraph (a) of this subsection (1) within thirty days after any change of control of the insurance company. Any extension granted pursuant to paragraph (c) of this subsection (1) shall be automatically rescinded in the event of such a change of control. The insurance company is not required to increase its capital and surplus if the transfer of ownership occurs because of death and the ownership is transferred solely to one or more natural persons, each of whom would be an heir of the decedent if the decedent had died intestate.

(2) The cash or securities representing the minimum capital or guaranty fund and surplus required by paragraph (a) of subsection (1) of this section shall be deposited, in the case of domestic companies, with the commissioner in the manner provided by law and, in the case of foreign or alien companies, with the commissioner or with the duly authorized officer of some other state of the United States; except that the guaranty fund of mutual companies shall be construed to include deposits held for the benefit of policyholders as provided in this title (except article 15) and article 14 of title 24, C.R.S.

(3) The deposit shall be held by the commissioner for the benefit of all policyholders wherever located. For a foreign or alien insurer to be allowed credit for deposits in other jurisdictions, such deposits must be held for the benefit of all policyholders wherever located and not solely or with preference for those in the depository jurisdiction.

Source: L. 13: p. 340, § 25. **C.L.** § 2495. **CSA:** C. 87, § 23. **L. 51:** p. 466, § 1. **CRS 53:** § 72-1-36. **L. 63:** p. 570, § 1. **C.R.S. 1963:** § 72-1-36. **L. 69:** p. 527, § 2. **L. 79:** (1)(c) and (1)(d) added, p. 359, § 4, effective July 1. **L. 91:** (1) and (2) R&RE, p. 1244, § 6, effective July 1. **L. 92:** (1)(b) amended, p. 1766, § 2, effective March 20; (2) amended, p. 1545, § 34, effective May 20. **L. 2004:** (2) amended, p. 899, § 12, effective May 21. **L. 2012:** (2) amended, (HB 12-1266), ch. 280, p. 1504, § 25, effective July 1.

Editor's note: Subsections (1)(a)(I)(B), (1)(a)(II)(B), (1)(a)(III)(B), and (1)(a)(IV)(B) provided for the repeal of subsections (1)(a)(I), (1)(a)(II), (1)(a)(III), and (1)(a)(IV), respectively, effective July 1, 1992. (See L. 91, p. 1244.)

Cross references: For deposit and safekeeping of securities, see § 10-3-210.

10-3-202. Surplus ascertained - disposition of. Surplus of domestic insurance companies shall be ascertained by offsetting as a liability against the company's admitted assets the par value of its outstanding capital stock, if any, its reserve liability, and its current obligations of every kind. The excess of said admitted assets over said liabilities shall be the company's surplus. Surplus of domestic stock insurance companies belongs to their stockholders, and such part of the surplus may be apportioned or paid to policyholders, beneficiaries, and annuity and supplementary contract holders as the companies may from time to time determine.

Source: L. 25: p. 312, § 1. **CSA:** C. 87, § 42. **CRS 53:** § 72-2-2. **C.R.S. 1963:** § 72-2-1. **L. 69:** p. 491, § 2. **L. 2004:** Entire section amended, p. 1061, § 7, effective July 1.

10-3-203. Additional deposits - withdrawals. Any domestic insurance company depositing its insurance reserves with the commissioner under the optional reserve deposit law, section 10-7-101, at its option and in addition to its insurance reserves deposit, may also deposit with the commissioner approved securities not less in amount than the reserve required to mature any or all of the company's other contractual obligations of every kind designated at the time the deposits are made. Such additional deposits shall be to secure the payment of such other contractual obligations so designated. In determining the amount of deposit to be maintained with the commissioner on account of insurance or other reserves, he shall make proper deductions from the mathematical reserves for all indebtedness to the company on account of each policy and each contractual obligation not exceeding the reserve thereon, and for deferred and uncollected premiums on the policies and for the reserve on such part of each policy as may be reinsured as provided by law. Any amount at any time on deposit in excess of the amount required may be withdrawn by the depositing company. Whenever any such company makes an application to withdraw any excess deposit, the commissioner may accept the estimate or calculation of the company of such reserves or, at his option, may have a calculation or estimate thereof made for said purpose or an appraisal of the depositing company's securities, or both, at the expense of the company so applying, at such reasonable expense as may be agreed to by the company.

Source: L. 31: p. 421, § 1. **CSA:** C. 87, § 55. **CRS 53:** § 72-3-3. **C.R.S. 1963:** § 72-3-3.

10-3-204. Payment of dividends. (1) The amount of dividend payments by any domestic insurance company is wholly within the discretion of its directors or of the duly constituted executive committee thereof. No dividend shall be paid except from the company's surplus.

(2) It is unlawful for the directors, trustees, managers, or officers of any domestic insurance company, directly or indirectly, to make or pay any dividends or pay any interest, bonus, or other allowance in lieu of dividends, other than premium refunds and deductions guaranteed, except from the company's surplus and from profits arising from the company's business. Any person who is found guilty of violating any provision of this section shall be punished by a fine of not more than one thousand dollars.

Source: L. 25: p. 313, § 2. **L. 33:** p. 615, § 2. **CSA:** C. 87, § 43. **CRS 53:** § 72-2-3. **C.R.S. 1963:** § 72-2-2.

10-3-205. Manner of paying surplus. Every policyholder on all participating policies issued shall be permitted at the time the first dividend is declared to select from among the options set forth in the policy the manner and method of the payment of the surplus to be annually apportioned to his policy.

Source: L. 13: p. 353, § 49. **C.L.** § 2522. **CSA:** C. 87, § 63. **CRS 53:** § 72-3-10. **C.R.S. 1963:** § 72-3-10.

10-3-206. Security deposits - certificates. (1) The commissioner shall receive and hold on deposit, in the manner provided in this law, the securities of domestic companies that are deposited by any such company under the provisions of this title (except article 15) and article 14 of title 24, C.R.S., for the purpose of securing policyholders or to comply with any similar law of another state to enable the company to transact business in such state. All securities so offered for deposit shall belong to and be the sole property of such company and shall be free and clear of any claims whatsoever, and the commissioner shall determine the same by proper inquiry.

(2) The commissioner shall furnish to such company a certificate, under his hand and official seal, certifying that he holds said securities in trust for the benefit of the policyholders of such company.

Source: L. 13: p. 325, § 10. **L. 21:** p. 454, § 2. **C.L.** § 2480. **CSA:** C. 87, § 9. **CRS 53:** § 72-1-9. **C.R.S. 1963:** § 72-1-9. **L. 92:** (1) amended, p. 1545, § 35, effective May 20. **L. 2004:** (1) amended, p. 900, § 13, effective May 21. **L. 2012:** (1) amended, (HB 12-1266), ch. 280, p. 1504, § 26, effective July 1.

Cross references: For procedure for deposit and commissioner's duty to safeguard, see § 10-3-210.

10-3-207. Fees paid by insurance companies. (1) Every entity regulated by the division in this state shall pay the following fees to the division:

(a) For investigating and processing an initial application for authorization or licensure as a foreign or domestic insurance company to do business in this state, a nonrefundable fee of five hundred dollars, which fee shall accompany each application for authorization or licensure;

(b) In each year subsequent to 1992, in addition to any fee collected under paragraph (a) of this subsection (1), every insurance company, interinsurance company, fraternal benefit society, health maintenance organization, and nonprofit hospital, medical-surgical, and health service corporation licensed or authorized in this state that is regulated by the division of insurance shall make an annual nonrefundable payment on or before March 1 of each year based on the schedule specified in this paragraph (b) at the time of authorization and each subsequent renewal year. For nonadmitted insurers and accredited reinsurers, the fee specified in this paragraph (b) shall be considered to include the fee pursuant to paragraph (a) of this subsection (1):

(I) For insurance companies, interinsurance companies, fraternal benefit societies, health maintenance organizations, and nonprofit hospital, medical-surgical, and health service corporations that have prior year's direct written premiums, gross contract funds, or charges received in Colorado not exceeding one million dollars, a fee of six hundred seventy dollars;

(II) For insurance companies, interinsurance companies, fraternal benefit societies, health maintenance organizations, and nonprofit hospital, medical-surgical, and health service corporations that have prior year's direct written premiums, gross contract funds, or charges received in Colorado in excess of one million dollars but not exceeding ten million dollars, a fee of two thousand ten dollars. Any insurance company that did not write at least eighty thousand dollars of taxable premiums in the previous year in Colorado shall not exceed the fee as otherwise would have been payable pursuant to subparagraph (I) of this paragraph (b).

(III) For insurance companies, interinsurance companies, fraternal benefit societies, health maintenance organizations, and nonprofit hospital, medical-surgical, and health service corporations that have prior year's direct written premiums, gross contract funds, or charges received in Colorado in excess of ten million dollars, a fee of three thousand three hundred forty-five dollars. Any insurance company that did not write at least one hundred twenty thousand dollars of taxable premium in Colorado shall not exceed the fee as otherwise would have been payable pursuant to subparagraph (II) of this paragraph (b).

(c) (Deleted by amendment, L. 92, p. 1545, § 36, effective July 1, 1992.)

(d) and (e) Repealed.

(f) (I) For the purpose of providing adequate funds to the division for market analysis, investigation, and enforcement of article 11 of this title and rules adopted pursuant to said article 11, in addition to any other fee collected pursuant to this subsection (1), each title insurer regulated by the division pursuant to article 11 of this title shall pay a nonrefundable annual fee on or before March 1 of each year. This fee shall be established by the commissioner in an amount sufficient to support two full-time equivalents within the division.

(II) Repealed.

(III) Notwithstanding any provision of section 10-1-103 or 10-1-108 (9) to the contrary, all fees and surcharges collected pursuant to this paragraph (f) shall be transmitted to the state treasurer, who shall deposit the same in the division of insurance cash fund created in section 10-1-103, and shall be subject to annual appropriation to the division and to the department of law for the purposes set forth in this paragraph (f).

(IV) Notwithstanding section 24-1-136 (11)(a)(I), commencing January 1, 2009, the division shall provide annual reports to the joint budget committee, the senate business, labor, and technology committee, and the house business affairs and labor committee, or any successor committees, and shall post on the division's website a statistical report of the number of enforcement actions taken, market trends associated with title insurance and real estate transactions, and consumer complaints supported by the fee in subparagraph (I) of this paragraph (f).

(1.5) Every entity regulated by the division of insurance not identified in paragraph (b) of subsection (1) of this section shall pay a fee of five hundred dollars at the time of its license or authorization renewal.

(2) Fees collected by the division of insurance pursuant to this section shall be transmitted to the state treasurer and credited to the division of insurance cash fund, created in section 10-1-103 (3).

(3) (Deleted by amendment, L. 92, p. 1545, § 36, effective July 1, 1992.)

(4) Fair and reasonable fees for various administrative services of the division of insurance, including but not limited to copying, record searches, computer listings, computer disks or tapes, and requests for any such services from individuals, shall be determined by the commissioner.

(5) Notwithstanding the amount specified for any fee in this section, the commissioner by rule or as otherwise provided by law may reduce the amount of one or more of the fees if necessary pursuant to section 24-75-402 (3), C.R.S., to reduce the uncommitted reserves of the fund to which all or any portion of one or more of the fees is credited. After the uncommitted reserves of the fund are sufficiently reduced, the commissioner by rule or as otherwise provided

by law may increase the amount of one or more of the fees as provided in section 24-75-402 (4), C.R.S.

Source: L. 13: p. 331, § 14. **C.L.** § 2484. **CSA:** C. 87, § 12. **L. 53:** p. 369, § 1. **CRS 53:** § 72-1-12. **L. 59:** p. 507, § 2. **C.R.S. 1963:** § 72-1-12. **L. 65:** pp. 752, 753, §§ 1, 2. **L. 71:** p. 693, § 1. **L. 77:** (1)(q) added, p. 503, § 1, effective March 7. **L. 78:** (1)(h), (1)(i), (2)(d), and (2)(e) amended, p. 290, § 4, effective July 1. **L. 86:** (1)(d), (1)(e), (2)(d), and (2)(e) amended, p. 554, § 4, effective July 1. **L. 89:** (1)(d), (1)(e), (1)(j), (2)(d), and (2)(e) amended, p. 436, § 6, effective July 1. **L. 91:** Entire section amended, p. 1229, § 4, effective June 5. **L. 92:** Entire section amended, p. 1545, § 36, effective July 1. **L. 95:** IP(1)(b) amended, p. 490, § 3, effective May 16. **L. 96:** (1)(d) added, p. 684, § 1, effective August 1. **L. 97:** (1)(b) amended, p. 1413, § 5, effective June 3; (1)(e) added, p. 1043, § 5, effective August 6. **L. 98:** (5) added, p. 1325, § 26, effective June 1. **L. 2006:** (1)(e) amended, p. 1209, § 1, effective May 26; (1)(d) repealed, p. 1490, § 10, effective June 1. **L. 2007:** (1)(f) added, p. 1749, § 1, effective June 1. **L. 2008:** IP(1) amended, p. 1880, § 12, effective August 5. **L. 2010:** (1)(e) repealed, (HB 10-1385), ch. 204, p. 884, § 9, effective May 5. **L. 2017:** (1)(f)(IV) amended, (SB 17-044), ch. 4, p. 6, § 2, effective August 9.

Editor's note: (1) Subsection (1)(f)(II)(B) provided for the repeal of subsection (1)(f)(II), effective July 1, 2008. (See L. 2007, p. 1749.)

(2) Subsection (1)(e) was relocated to § 10-3-207.5 in 2010.

Cross references: For disposition of fees, see § 10-1-108.

10-3-207.5. Funding for insurance fraud investigations and prosecutions - creation of fund. (Repealed)

Source: L. 2010: Entire section added with relocations, (HB 10-1385), ch. 204, p. 882, § 1, effective May 5. **L. 2012:** Entire section repealed, (SB 12-110), ch. 158, p. 560, § 2, effective July 1.

Editor's note: This section was similar to former § 10-3-207 (1)(e) as it existed prior to 2010.

10-3-208. Financial statements. (1) All insurance companies doing business in this state, unless otherwise provided in this title (except article 15) and article 14 of title 24, C.R.S., shall make and file with the commissioner annually, on or before the first day of March in each year, a statement under oath, upon a form to be prescribed by the commissioner, stating the amount of all premiums collected or contracted for in this state or from residents thereof, in cash or notes, by the company making such statement during the year ending the last day of December next preceding; the amounts actually paid policyholders on losses and the amounts paid policyholders as returned premiums by property and casualty insurance companies; the amount of insurance reinsured in other companies authorized to do business in this state and the amount of premiums paid therefor; the amount of insurance reinsured in companies, naming them, not authorized to do business in this state and the amount of premiums paid therefor; and

the amount of reinsurance accepted from admitted companies and the premiums received from such reinsurance on residents of this state or risks located in this state, with the name of the companies so reinsured. The annual statement made to the commissioner pursuant to this section or other provisions of said references shall at least include the substance of that which is required by what is known as the convention blank form adopted from year to year by the national association of insurance commissioners, including any instructions, procedures, and guidelines not in conflict with any provision of this title for completing the convention blank form.

(2) The commissioner may require any insurance company authorized to do business in this state to submit interim financial statements and reports on a monthly or quarterly basis in such form as he prescribes, as deemed necessary in the public interest.

(3) Each domestic, foreign, and alien insurer that is authorized to transact the business of insurance in this state shall on or before March 1 of each year file with the national association of insurance commissioners a copy of its annual statement convention blank, along with such additional filings as prescribed by the commissioner for the preceding year. The information filed with the national association of insurance commissioners shall include the signed jurat page and the actuarial certification, if applicable. Any amendments and addendums to the annual statement filing subsequently made with the commissioner shall also be filed with the national association of insurance commissioners.

(4) Foreign insurers that are domiciled in a state which has a law substantially similar to subsection (3) of this section shall be deemed in compliance with the provisions of said subsection (3).

(5) In the absence of actual malice, members of the national association of insurance commissioners, their duly authorized committees, subcommittees, and task forces, their delegates, employees of the national association of insurance commissioners, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the commissioner under the authority of this section and shall not be subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the required filings.

(6) Examination synopses concerning insurance companies that are submitted to the division by the national association of insurance commissioners' insurance regulatory information system are confidential and shall not be disclosed by the division.

(7) (a) In preparing the statements required by subsection (1) of this section, all insurance companies shall follow the instructions, procedures, and guidelines of the national association of insurance commissioners. If the initial application of any such instruction, procedure, or guideline would cause a reduction in the total capital and surplus of a domestic insurer of ten percent or more or would cause the capital and surplus of a domestic insurer to fall to or below the company action level as defined by the commissioner by rule, such insurer may, within thirty days after the effective date of such instruction, procedure, or guideline, file with the commissioner a request to phase in the effect of the instruction, procedure, or guideline over a period not to exceed three years or a time period approved by the commissioner.

(b) Any request made pursuant to paragraph (a) of this subsection (7) shall include a complete analysis, in a form prescribed by the commissioner, of the impact upon the insurer making the request that is expected to result from application of the subject instruction, procedure, or guideline and, if a phase-in is requested, a description of the insurer's plan for the

phase-in period. The commissioner shall not deny a request for a phase-in except upon notice and the opportunity for a hearing as provided in section 24-4-105, C.R.S.

(c) Any request for a hearing made pursuant to paragraph (b) of this subsection (7) shall include a description of the basis on which relief is sought. Upon receiving such a request, the commissioner shall, with regard to the insurer making the request, postpone the effective date of the subject instruction, procedure, or guideline pending the conclusion of the hearing and the taking of final agency action thereon. The hearing shall commence within sixty days after the commissioner receives the request and shall be conducted in accordance with section 24-4-105, C.R.S.

(8) Repealed.

Source: L. 13: p. 331, § 15. **C.L.** § 2485. **L. 23:** p. 388, § 2. **CSA:** C. 87, § 13. **L. 53:** p. 363, § 1. **CRS 53:** § 72-1-13. **C.R.S. 1963:** § 72-1-13. **L. 69:** p. 503, § 1. **L. 91:** (1) and (2) amended, p. 1232, § 5, effective June 5; (3) to (6) added, p. 1246, § 7, effective July 1. **L. 92:** (1) amended, p. 1547, § 37, effective May 20. **L. 97:** (7) added, p. 91, § 1, effective March 24. **L. 2004:** (1) amended, p. 900, § 14, effective May 21. **L. 2006:** (8) added, p. 1429, § 1, effective August 7. **L. 2011:** (8) repealed, (HB 11-1033), ch. 93, p. 275, § 1, effective April 8. **L. 2012:** (1) amended, (HB 12-1266), ch. 280, p. 1504, § 27, effective July 1.

Cross references: For reports generally, see § 10-3-109.

10-3-209. Tax on premiums collected - exemptions - penalties - filing system - division to contract with third parties - rules - repeal. (1) (a) All insurance companies writing business in this state, including, without limitation, those defined in section 10-1-102 (6), except a disqualified insurance company, shall pay to the division of insurance a tax on the gross amount of all premiums collected or contracted for on policies or contracts of insurance covering property or risks in this state during the previous calendar year, after deducting from such gross amount the amount received as reinsurance premiums on business in this state, and the amount refunded under credit life and credit accident and health insurance policies on account of termination of insurance prior to the maturity date of the indebtedness, and, in the case of companies other than life, the amounts paid to policyholders as return premiums, which shall include dividends or unabsorbed premiums or premium deposits returned or credited to policyholders.

(b) (I) The rate of tax is as follows:

(A) For companies not exempted or charged a different rate of tax by another provision of this section, the rate of tax on the gross amount shall be:

Premium collected or contracted for during:	**Rate of tax:**
1996	2.20%
1997	2.15%
1998	2.10%
1999	2.05%
2000 and thereafter	2.00%

(B) For direct written premiums in 2025, for companies maintaining a home office or a regional home office in this state, the rate of tax on the gross amount is one percent. On and after January 1, 2026, the tax rate is two percent.

(II) For purposes of this subsection (1)(b), except as otherwise provided in subsection (1)(b)(II.5) of this section, any company is deemed to maintain a home office or regional home office in this state if such company either:

(A) Substantially performs in this state the following functions, or substantially equivalent functions, for the company for each state in which the company is licensed, or for three or more of such states: Actuarial, medical, legal, approval or rejection of applications, issuance of policies, information and service, advertising and publications, public relations, hiring, testing, and training of sales and service forces; or

(B) Maintains significant direct insurance operations in this state that are supported by functional operations which are both necessary for and pertinent to a line or lines of business written by the company in this state.

(II.5) To be deemed to maintain a home office or regional home office in this state, a company must meet one of the criteria set forth in subsection (1)(b)(II) of this section and also have a workforce in the state that is greater than or equal to:

(A) Two percent of the company's total domestic workforce, for taxes that are due and payable for calendar year 2022;

(B) Two and one-quarter percent of the company's total domestic workforce, for taxes that are due and payable for calendar year 2023; and

(C) Two and one-half percent of the company's total domestic workforce, for taxes that are due and payable for calendar year 2024 and each calendar year thereafter.

(II.7) For purposes of the calculation required in subsection (1)(b)(II.5) of this section, a workforce includes all employees of the company; the company's ultimate parent entity; subsidiaries; and affiliates, as defined in section 10-3-801 (1), but excludes agents, brokers, and their staff.

(III) Any company desiring to qualify an office in this state as a home or regional home office shall make application for qualification to the commissioner on forms prescribed by the commissioner and shall submit proof that it is operating a home or a regional home office in this state. Applications for companies that were not approved in the immediate preceding year shall be received by the commissioner by December 31 of the year immediately preceding the year for which the application for qualification is being made. Applications for companies that were approved in the immediate preceding year shall be received by the commissioner by March 1 of the year for which qualification is being made. Applications for companies that were approved in the immediate preceding year received through March 31 shall pay a late charge of one hundred dollars per day for each day after March 1 that any such application is received by the commissioner. Applications received after March 31 shall be denied. The provisions of subsection (2) of this section shall not apply to companies maintaining a home office or regional home office in this state.

(IV) Subsections (1)(b)(I)(B), (1)(b)(II), (1)(b)(II.5), (1)(b)(II.7), and (1)(b)(III) of this section and this subsection (1)(b)(IV) are repealed, effective December 31, 2026.

(c) The taxes prescribed in paragraph (b) of this subsection (1) shall constitute all taxes collectible under the laws of this state against any such insurance companies, and no other occupation tax or other taxes shall be levied or collected from any insurance company by any

county, city, or town within this state, but this title (except article 15) and article 14 of title 24, C.R.S., shall not be construed to prohibit the levy and collection of state, county, school, and municipal taxes upon the real and personal property of such companies, nor shall it include or prohibit the levy and collection of a tax to be paid on net workers' compensation premiums, as provided under the "Colorado Medical Disaster Insurance Fund Act", part 3 of article 46 of title 8, C.R.S.

(d) (I) All fraternal and benevolent associations organized under the laws of this state and doing business in this state shall be exempt from the provisions of this section.

(II) and (III) Repealed.

(IV) Except to the extent provided in subsection (2) of this section, the tax imposed by this section shall not apply to premiums collected or contracted for after December 31, 1968, on policies or contracts issued in connection with a pension, profit sharing, or annuity plan established by an employer for employees if contributions by such employer thereunder are deductible by such employer in determining such employer's net income as defined in section 39-22-304, and shall not apply to premiums collected or contracted for after December 31, 1968, on policies or contracts purchased for an employee by an employer if such employer is exempt under section 39-22-112 from the tax imposed by article 22 of title 39, or is a state, a political subdivision of a state, or an agency or instrumentality of a state or political subdivision of a state. The tax imposed by this section shall not apply to annuity considerations collected or contracted for after December 31, 1976, except to the extent provided in subsection (2) of this section and except for taxes that are due and payable for the calendar year 2021 and each calendar year thereafter, this exemption only applies to annuity considerations that are used as qualified funding assets under section 130 of the internal revenue code or annuity considerations that are purchased in connection with:

(A) A plan under section 401 (a) of the federal "Internal Revenue Code of 1986", as amended;

(B) A Roth 401(k) under section 402A of the federal "Internal Revenue Code of 1986", as amended;

(C) A tax-sheltered annuity plan under section 403 (b) of the federal "Internal Revenue Code of 1986", as amended;

(D) An individual retirement account under section 408 (a) of the federal "Internal Revenue Code of 1986", as amended;

(E) An individual retirement annuity under section 408 (b) of the federal "Internal Revenue Code of 1986", as amended;

(F) A simplified employee pension under section 408 (k) of the federal "Internal Revenue Code of 1986", as amended;

(G) A simple retirement account under section 408 (p) of the federal "Internal Revenue Code of 1986", as amended;

(H) A deferred compensation plan under section 457 of the federal "Internal Revenue Code of 1986", as amended;

(I) A Roth 457 under section 457 of the federal "Internal Revenue Code of 1986", as amended; and

(J) A qualified retirement plan not specified in this subsection (1)(d)(IV) or a Roth version of any qualified retirement plan.

(V) Repealed.

(e) The taxes provided for in this section shall be due and payable on the first day of March in each year. Any company failing or refusing to render such statement and information, or to pay taxes as specified in this section, for more than thirty days after the time specified, shall be liable to a penalty of up to one hundred dollars for each additional day of delinquency, to be assessed by the commissioner. If the tax paid is less than the full amount prescribed by this section, interest at the rate of one percent per month or fraction thereof on the unpaid amount shall be charged from the date on which payment was due to the date on which full payment is made, and a penalty of up to twenty-five percent of the unpaid amount may be assessed by the commissioner. The commissioner may suspend the certificate of authority of a delinquent company until such taxes and penalty, should any penalty be imposed, are fully paid.

(f) In computing assets for the purpose of this section, the investments of any such company in the bonds, notes, or other obligations of the United States of America, or any instrumentality of the United States, the obligations of which are guaranteed by the United States, and deferred or uncollected insurance premiums and annuity considerations shall first be deducted. Any company claiming entitlement to any reduced rate provided in this section shall present such evidence in justification of its claim as may be required by the commissioner.

(g) Repealed.

(2) When, by the laws of any other state, any taxes and fees in the aggregate, fines, penalties, deposits of money or securities or other obligations, prohibitions, or requirements are imposed upon insurers organized under any law of this state and transacting business in such other state, or upon the agents of such insurer, greater in aggregate amount than those imposed upon similar insurers by the laws of this state, or when the laws of any other state require insurers of this state to deposit money or security for the benefit or protection of citizens of such other state, or when the laws or officers of any other state prohibit insurers of this state from transacting business therein without a special examination of the insurers or a computation of their liabilities by the officers of that state, the same taxes and fees in the aggregate, fines, penalties, deposits, examinations, obligations, and requirements may be imposed by the commissioner upon all insurers doing business in this state that are incorporated or organized under the laws of such other state and upon their agents. For the purpose of this section, an alien insurer may be deemed to be domiciled in a state designated by it wherein it has established its principal office or agency in the United States or maintains the largest amount of its assets. If no such office or agency is established, its domicile is the country under laws of which it is formed.

(3) (a) Anything in subsection (1) of this section to the contrary notwithstanding, any insurance company doing business in this state which was liable for payment of more than five thousand dollars in taxes, as provided in this section, during the preceding calendar year shall, on and after January 1, 1971, pay quarterly estimates of such taxes as provided in paragraphs (b) to (d) of this subsection (3).

(b) Such estimated taxes shall become due and payable on the last day of the month following the close of any calendar quarter of the year, except for the fourth quarter which shall be due March 1 and shall include adjustments for the preceding calendar year. Any company failing or refusing to pay such estimated taxes for more than thirty days after the time specified shall be liable to a penalty of up to one hundred dollars for each additional day of delinquency, to be assessed by the commissioner. Failure of a company to make quarterly payments, if required, each payment to be of at least one-fourth of either the total tax paid during the preceding calendar year or eighty percent of the actual quarterly tax for the current calendar

year, whichever is lesser, shall be considered and treated the same as a failure or refusal to pay the estimated taxes and shall subject the company to the penalties provided in this subsection (3)(b). The amount of estimated taxes and the penalties collected shall be paid to the division of insurance, and the commissioner may suspend the certificate of authority of such delinquent company until such estimated taxes and penalty, should any penalty be imposed, are fully paid.

(c) Estimated taxes paid pursuant to this subsection (3) shall be based on the estimated amount of taxable premiums during the preceding calendar quarter. Calendar quarter estimates of taxes may include adjustments for any previous calendar quarter estimates of taxes and allowable tax credits claimed by the company in accordance with part 1 of article 3.5 of this title 10, part 2 of article 36 of title 24, part 2 of article 46 of title 24, part 21 of article 22 of title 39, or any other law authorizing a credit against premium tax liability. Estimated taxes shall be paid on the basis of such adjusted estimates.

(d) (I) Adjustments in payments of estimated taxes for any calendar year shall be made at the time of the filing of the annual statement required under section 10-3-208 and the payment of taxes required by this section. If, upon the filing of the annual statement, a company has overpaid its taxes for any calendar year, the company may either apply the overpayment to its calendar quarter estimates of taxes in a subsequent calendar year or claim a refund for the amount of the overpayment. If a company claims a refund, it shall file for such refund at the time of filing such annual statement, and, if the commissioner claims a deficiency, the commissioner shall notify the deficient company thereof.

(II) In calculating the amount of a refund claimed pursuant to subsection (3)(d)(I) of this section, the value of a nonrefundable tax credit claimed by the company must be applied first to the company's total tax liability, prior to applying any other payment made by the company regardless of the order in which such payments or credits were received. The refund must not exceed the total amount of any additional payments made by the company.

(4) (a) The division of insurance shall transmit all taxes, penalties, and fines it collects under this section to the state treasurer for deposit in the general fund; except that the state treasurer shall deposit amounts in the specified cash funds as follows:

(I) In the division of insurance cash fund created in section 10-1-103 (3), an amount that is equal to the general assembly's appropriation from the fund to the division for its direct and indirect expenditures less the total fee revenue that is deposited in the fund; except that the amount deposited in the fund under this subparagraph (I) shall not exceed five percent of all taxes collected under this section;

(II) In the wildfire emergency response fund created in section 24-33.5-1226 and the wildfire preparedness fund created in section 24-33.5-1227, the amount of the taxes, penalties, and fines that the general assembly appropriates to each of the cash funds; and

(III) Repealed.

(b) Repealed.

(5) For the purpose of auditing a company's tax statement, the commissioner or the commissioner's designee, which may include an independent examiner under section 10-1-204 (6), has the power to examine any books, papers, records, agreements, or memoranda bearing upon the matters required to be included in the tax statement. Such books, papers, records, agreements, or memoranda shall be made available upon request to the commissioner's office or the commissioner's designee.

(6) (a) All taxes, penalties, fines, fees, and associated filings required under this section must be submitted to the division through a secure web-based application system identified by the division. The commissioner may enter into a contract with a qualified third party, including the National Association of Insurance Commissioners, for a secure web-based application system that would allow premium taxes paid by insurance companies to be filed for multiple states on a single web-based application system. The third party may charge the insurance company a nominal fee for this service that is reasonably related to the overall cost of the service of collecting filings and payments and transmitting those filings and payments to the division. A fee charged by the third party as part of this subsection (6) is not subject to section 10-3-207 or subsection (4)(a) of this section.

(b) Pursuant to article 4 of title 24, the commissioner may promulgate rules necessary to implement, operate, and enforce this subsection (6).

(c) In contracting with a qualified third party for a secure web-based application system described in this subsection (6), the commissioner is exempt from the "Procurement Code", articles 101 to 112 of title 24.

(d) In submitting taxes, penalties, fines, fees, and associated filings required under this section to the division, an insurance company shall identify the total annual dollar amount of premiums collected or contracted for on policies or contracts of insurance covering property or risks in Colorado during the previous calendar year from entities that are exempt from taxation pursuant to section 10-3-209 (1)(d)(IV).

Source: L. 13: p. 332, § 16. **C.L.** § 2486. **L. 33:** p. 636, § 1. **CSA:** C. 87, § 14. **L. 41:** p. 515, § 1. **L. 53:** p. 378, § 1. **CRS 53:** § 72-1-14. **L. 55:** p. 443, § 1. **L. 59:** p. 505, § 1. **L. 60:** p. 149, § 1. **L. 61:** p. 438, § 1. **L. 63:** p. 568, §§ 1, 2. **C.R.S. 1963:** § 72-1-14. **L. 65:** p. 755, § 1. **L. 69:** pp. 504-506, §§ 1-4, 1. **L. 70:** p. 243, § 1. **L. 71:** p. 694, § 1. **L. 73:** pp. 833, 834, §§ 1, 2. **L. 75:** (1)(c) amended, p. 310, § 55, effective September 1. **L. 77:** (1)(d)(IV) amended, p. 504, § 1, effective June 21. **L. 81:** (1)(d)(IV) and (3)(b) amended, p. 525, § 1, effective May 13. **L. 86:** (1)(d)(V) added, p. 549, § 2, effective July 1. **L. 87:** (1)(d)(IV) amended, p. 1451, § 27, effective June 22. **L. 90:** (1)(c) amended, p. 558, § 14, effective July 1. **L. 92:** (1)(b)(II), (1)(c), and (4) amended, p. 1548, § 38, effective May 20. **L. 95:** (1)(b)(I) amended, p. 490, § 4, effective May 16. **L. 96:** (1)(a) and (1)(b) amended, p. 551, § 1, effective April 24. **L. 97:** (5) added, p. 531, § 4, effective April 24. **L. 2000:** (1)(a) amended, p. 1616, § 2, effective August 2. **L. 2003:** (1)(a) amended, p. 616, § 9, effective July 1. **L. 2004:** (1)(c) amended, p. 900, § 15, effective May 21. **L. 2012:** (1)(c) amended, (HB 12-1266), ch. 280, p. 1505, § 28, effective July 1. **L. 2013:** (4) amended, (SB 13-270), ch. 250, p. 1316, § 5, effective May 23. **L. 2014:** (4)(a) amended, (HB 14-1195), ch. 117, p. 418, § 1, effective July 1. **L. 2016:** (1)(b) amended, (SB 16-165), ch. 278, p. 1145, § 1, effective January 1, 2017. **L. 2019:** (4)(a) amended, (HB 19-1168), ch. 204, p. 2187, § 2, effective May 17. **L. 2020:** (4)(a)(III) amended, (SB 20-215), ch. 201, p. 1001, § 10, effective June 30. **L. 2020, 1st Ex. Sess.:** (3)(b), (3)(c), and (3)(d) amended, (HB 20B-1006), ch. 5, p. 31, § 1, effective December 7. **L. 2021:** (1)(a) amended, (HB 21-1311), ch. 298, p. 1786, § 12, effective June 23; IP(1)(b)(II), (1)(d)(IV), and (5) amended and (1)(b)(II.5) and (1)(b)(II.7) added, (HB 21-1312), ch. 299, p. 1789, § 2, effective July 1. **L. 2023:** (1)(d)(II), (1)(d)(III), and (1)(g) repealed, (HB 23-1121), ch. 35, p. 118, § 1, effective August 7. **L. 2024:** (6) added, (HB 24-1119), ch. 38, p. 137, § 2, effective March 22; (4)(a)(III)(A) amended and (4)(a)(III)(C) added, (HB 24-1470), ch. 491, p. 3446, § 2, effective June 7. **L. 2025:** (6)(d) added, (HB 25-

1296), ch. 202, p. 912, § 3, effective May 16. **L. 2025, 1st Ex. Sess.:** IP(1)(b)(I) and (1)(b)(I)(B) amended and (1)(b)(IV) added, (HB 25B-1003), ch. 7, p. 24, § 2, effective August 28.

Editor's note: (1) Subsection (1)(d)(V)(B) provided for the repeal of subsection (1)(d)(V), effective July 1, 1989. (See L. 86, p. 549.)

(2) Subsection (4)(b)(II) provided for the repeal of subsection (4)(b), effective July 1, 2014. (See L. 2013, p. 1316.)

(3) Subsection (4)(a)(III)(C) provided for the repeal of subsection (4)(a)(III), effective July 1, 2025. (See. L. 2024, p. 3446.)

Cross references: (1) For required equality as to liabilities under subsection (1)(b) imposed by statute on domestic and foreign corporations, see article 115 of title 7; for legal effect, when discrimination exists, see American Smelting & Refining v. Colorado, 204 U.S. 103, 27 S. Ct. 198, 51 L. Ed. 393; for annual financial statements, see § 10-3-208.

(2) For the legislative declaration in HB 21-1311, see section 1 of chapter 298, Session Laws of Colorado 2021. For the legislative declaration in HB 21-1312, see section 1 of chapter 299, Session Laws of Colorado 2021. For the legislative declaration in HB 24-1119, see section 1 of chapter 38, Session Laws of Colorado 2024. For the legislative declaration in HB 25-1296, see section 1 of chapter 202, Session Laws of Colorado 2025. For the legislative declaration in HB 25B-1003, see section 1 of chapter 7, Session Laws of Colorado 2025, First Extraordinary Session.

10-3-210. Deposit and safekeeping of securities. (1) (a) The commissioner shall give receipts for all securities deposited with the commissioner, as required or permitted by law, to the company depositing them.

(b) If the company depositing securities in accordance with paragraph (a) of this subsection (1) is adjudged insolvent, such deposit shall be released only upon the entry of an order of a court acting in accordance with the provisions of part 5 of this article. If a company that has not been adjudged insolvent elects to dissolve, the commissioner may release securities under joint control upon a showing by the insurance company satisfactory to the commissioner that all debts, obligations, and liabilities of the insurance company have been paid and discharged, or adequate provisions for payment and discharge have been made, and upon return of the company's certificate of authority to the commissioner.

(c) (Deleted by amendment, L. 2004, p. 1061, § 8, effective July 1, 2004.)

(d) If the company depositing securities in accordance with paragraph (a) of this subsection (1) remains solvent, the commissioner shall permit such company, or its assigns, to:

(I) Collect and receive the interest and dividends on deposited securities; and

(II) Withdraw any deposited securities if the company simultaneously deposits other securities to replace those withdrawn.

(e) The provisions of this subsection (1) shall not apply to securities subject to part 12 of this article.

(2) (a) (I) Notwithstanding any other provision of law, the securities qualified for deposit under this section may be deposited as provided in part 12 of this article with a clearing corporation or held in the federal reserve book-entry system.

(II) Securities deposited with a clearing corporation or held in the federal reserve book-entry system and used to meet the deposit requirements set forth in this section shall be under the control of the commissioner and shall not be withdrawn by the company without the approval of the commissioner.

(b) The commissioner may prescribe or approve reasonable arrangements and safeguards under which a solvent company may sell a particular deposited security if the company:

(I) Immediately reinvests the proceeds of the sale in other securities eligible for deposit under this article; and

(II) Deposits other securities to replace those securities that were sold.

(c) Any owner, nominee owner, depository, or custodian of securities held in accordance with paragraph (a) of this subsection (2) shall not sell, claim against, or otherwise dispose of said securities without written permission of the commissioner.

(d) Any company holding securities in accordance with paragraph (a) of this subsection (2) shall provide to the commissioner evidence issued by its custodian or member bank through which such company has deposited such securities in a clearing corporation or through which such securities are held in the federal reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank and that the records of the custodian, other participant, or member bank reflect that such securities are held subject to the order of the commissioner.

(e) If the company depositing securities in accordance with paragraph (a) of this subsection (2) remains solvent, the commissioner shall permit such company, or its assigns, to:

(I) Collect and receive the interest and dividends on those deposited securities; and

(II) Withdraw any deposited securities if the company simultaneously deposits other securities to replace those withdrawn.

(f) If the company depositing securities in accordance with paragraph (a) of this subsection (2) is adjudged insolvent, such deposit shall be released only upon the entry of an order of a court acting in accordance with the provisions of part 5 of this article. If a company that has not been adjudged insolvent elects to dissolve, the commissioner may release securities under joint control upon a showing satisfactory to the commissioner that all debts, obligations, and liabilities of the insurance company have been paid and discharged, or adequate provisions for payment and discharge have been made, and upon return of the company's certificate of authority to the commissioner.

(g) (I) The commissioner may designate any solvent national bank, state bank, or trust company located in the city and county of Denver as the commissioner's depository for receiving and holding as custodian any deposit of securities in accordance with paragraph (a) of this subsection (2).

(II) Any deposit received and held pursuant to this subsection (2) shall be received and held at the expense of the company.

Source: L. 25: p. 313, § 3. **CSA:** C. 87, § 44. **CRS 53:** § 72-2-4. **C.R.S. 1963:** § 72-2-3. **L. 83:** Entire section amended, p. 450, § 1, effective May 3. **L. 92:** (1) amended, p. 1549, § 39, effective May 20. **L. 96:** Entire section amended, p. 97, § 1, effective July 1. **L. 2004:** (1)(a), (1)(b), (1)(c), and (2)(f) amended, p. 1061, § 8, effective July 1.

Cross references: For requirement of deposit, see § 10-3-201; for certificate of deposit, see § 10-3-206.

10-3-211. Deposit only admitted assets. (1) Deposits made with the commissioner as permitted or required by law shall be only those admitted assets of the company that are securities eligible for the purpose of a deposit, as provided in section 10-3-235 (1) or (2). The company may deposit, withdraw, exchange, or substitute any security at any time if the total amount of securities remaining on deposit is no less than required by law.

(2) When a domestic insurance company reinsures all of its business in another company, the securities deposited by the reinsured company with the commissioner, subject to any existing liens against and restrictions upon them, may be assigned or transferred to the reinsuring company, and the latter company shall thereupon acquire all the rights, title, and interest of the reinsured company in and to such securities and shall be entitled to all the rights, benefits, and privileges of the reinsured company pertaining thereto. If a domestic company, having securities on deposit with the commissioner, reinsures all of its business, such securities may only be withdrawn, except for the purpose of exchange or substitution, upon a showing satisfactory to the commissioner that all debts, obligations, and liabilities of the insurance company have been paid and discharged, or adequate provisions for payment and discharge have been made, and upon return of the company's certificate of authority to the commissioner.

(3) (Deleted by amendment, L. 2004, p. 1062, § 9, effective July 1, 2004.)

Source: L. 33: p. 611, § 1. **CSA:** C. 87, § 45. **CRS 53:** § 72-2-5. **C.R.S. 1963:** § 72-2-4. **L. 69:** p. 491, § 3. **L. 2004:** Entire section amended, p. 1062, § 9, effective July 1.

10-3-212. Insolvency or impairment of stock insurance company. A stock insurance company is deemed insolvent when its admitted assets are less than all of its liabilities, excluding from such liabilities the aggregate amount of its outstanding capital stock, and is deemed impaired when its admitted assets are less than its liabilities, including as a liability the aggregate amount of its outstanding capital stock, or when its surplus is less than the minimum requirements of section 10-3-201.

Source: L. 25: p. 315, § 5. **CSA:** C. 87, § 46. **CRS 53:** § 72-2-6. **C.R.S. 1963:** § 72-2-5. **L. 69:** p. 544, § 2.

10-3-213. Investments eligible as admitted assets. (1) Domestic insurance companies may invest their funds in the categories of assets described in sections 10-3-215 to 10-3-230 and 10-3-242. Every such investment shall be an admitted asset of the company; except that, if the section describing a category of asset contains a quantitative limitation, an investment in that category of asset shall be an admitted asset under that section to the extent that it does not exceed such limitation. Any such limitation shall apply only with respect to the category of assets described in that section and shall not constitute a general prohibition and shall not be applicable to any other section. Except as provided in section 10-3-237, any investment, or part thereof, that does not qualify under any of said sections shall not be an admitted asset under the provisions of this part 2. Except as specifically provided in this title (except article 15) and article 14 of title 24, C.R.S., a domestic insurance company shall not be prohibited from

acquiring or holding an asset that is not an admitted asset, and such company may lend, pledge, sell, transfer, assign, hypothecate, dispose of, or exchange any asset acquired by it.

(2) Notwithstanding the provisions of subsection (1) of this section, an insurance company or other regulated entity to whom this section applies shall be required reasonably to diversify its investments made pursuant to sections 10-3-215 to 10-3-230 and 10-3-242 as to type and issue, and to maintain a sufficient degree of liquidity based on the nature of the business transacted. The commissioner may promulgate such reasonable rules and regulations as are necessary to carry out the provisions of this subsection (2), taking into consideration the standards of the national association of insurance commissioners. The commissioner may require an insurer or other regulated entity to show compliance by demonstrating that its investments are not overly concentrated in any one area, including without limitation the areas of duration, industry, issuer, or geographic location.

Source: L. 69: p. 491, § 5. **C.R.S. 1963:** § 72-2-19. **L. 85:** Entire section amended, p. 380, § 2, effective May 1. **L. 92:** Entire section amended, p. 1767, § 3, effective March 20; entire section amended, p. 1549, § 40, effective May 20. **L. 2004:** (1) amended, p. 901, § 16, effective May 21. **L. 2012:** (1) amended, (HB 12-1266), ch. 280, p. 1505, § 29, effective July 1.

Editor's note: Amendments to this section by Senate Bill 92-090 and House Bill 92-1090 were harmonized.

10-3-214. Quantitative investment limitations - manner of applying. In applying the investment limitations set forth in this part 2, which are expressed as percentages of a company's admitted assets, there shall be used as a base the total of all assets of the company that would be admitted under this title (except article 15) and article 14 of title 24, C.R.S., without regard to such limitations and without regard to any condition or restriction set forth in section 10-3-237 (2), and asset values will be those values determined at the current annual statement date or, in case of any statement or examination as of a date other than an annual statement date, those values determined at such other date. In applying any investment limitation set forth in this part 2, which is expressed as a percentage of a company's surplus, the amount of the company's surplus shall be that determined at the current annual statement date or, in the case of any statement or examination as of a date other than an annual statement date, the amount determined at such other date.

Source: L. 69: p. 492, § 5. **C.R.S. 1963:** § 72-2-20. **L. 92:** Entire section amended, p. 1550, § 41, effective May 20. **L. 2004:** Entire section amended, p. 901, § 17, effective May 21. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1505, § 30, effective July 1.

10-3-215. Evidences of indebtedness. (1) A domestic insurance company may invest in lawfully issued interest-bearing evidences of indebtedness, including interest-bearing bonds, bonds that provide for imputed interest payable at maturity, revenue bonds, debentures, and other instruments evidencing indebtedness for the payment of money:

(a) Issued by the United States, by an agency or instrumentality of the United States, or by any state, territory, district, or political subdivision of the United States;

(b) Guaranteed or insured as to the payment of principal and interest by the United States or any agency or instrumentality thereof, or by any state, territory, district, or political subdivision of the United States;

(c) Of counties, districts, townships, municipalities, and political subdivisions within the states, territories, and districts of the United States; except that investment in special improvement district obligations shall be limited to those which have received a designation or rating equivalent to or better than those specified in subsection (2)(b) of this section or, if not so designated or rated, have a credit enhancement approved by the commissioner;

(d) Issued by Canada, by provinces or districts of Canada, or by counties, districts, townships, municipalities, or political subdivisions of Canada, or guaranteed or insured as to the payment of principal and interest by Canada or by a province or district of Canada;

(e) Issued by institutions created under the laws of the United States, of any state, territory, or district of the United States, or of Canada or a province of Canada, which institutions are not referenced in subsection (1)(a), (1)(b), (1)(c), or (1)(d) of this section; but the aggregate value of all bonds and other evidences of indebtedness of any one institution that may be admitted assets under this section must not exceed three percent of the company's admitted assets except as:

(I) To those bonds and other evidences of indebtedness of insurance companies admitted to do business in a state of the United States or in the District of Columbia, for coinsurance or reinsurance purposes, in which case the bonds or other evidences of indebtedness must not exceed the greater of three percent of the domestic insurance company's admitted assets or five percent of the debtor insurance company's admitted assets or loans; or

(II) May be otherwise authorized under section 10-3-802;

(f) Of farm credit banks and banks for cooperatives, or other similar corporations organized under the laws of the United States;

(g) Repealed.

(h) Issued by, or guaranteed or insured as to the payment of principal and interest by, any foreign government other than those listed in paragraph (d) of this subsection (1); except that the aggregate value of all such bonds and other evidences of indebtedness which may be admitted assets pursuant to this paragraph (h) and paragraph (i) of this subsection (1) shall not exceed twenty percent of the domestic insurance company's admitted assets, and except that the aggregate amount of foreign investments that may be admitted assets pursuant to this paragraph (h) and to paragraph (i) of this subsection (1) in a single foreign jurisdiction shall not exceed:

(I) Ten percent of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating from a nationally recognized statistical rating organization recognized by the securities valuation office of the national association of insurance commissioners equivalent to securities valuation office rating 1 in the then current purposes and procedures manual of the securities valuation office; or

(II) Three percent of its admitted assets as to any other foreign jurisdiction.

(i) Of solvent foreign institutions other than those specified in paragraphs (e) and (j) of this subsection (1) which are not in default in the payment of interest on any of their bonds at the time the investment is made; except that the aggregate value of all such bonds and other evidences of indebtedness which may be admitted assets pursuant to this paragraph (i) and paragraph (h) of this subsection (1) shall not exceed twenty percent of the domestic insurance company's admitted assets, and except that the aggregate amount of foreign investments that

may be admitted assets pursuant to this paragraph (i) and to paragraph (h) of this subsection (1) in a single foreign jurisdiction shall not exceed:

(I) Ten percent of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating from a nationally recognized statistical rating organization recognized by the securities valuation office of the national association of insurance commissioners equivalent to securities valuation office rating 1 in the then current purposes and procedures manual of the securities valuation office; or

(II) Three percent of its admitted assets as to any other foreign jurisdiction.

(j) Issued by, or guaranteed or insured as to the payment of principal and interest by, the international bank for reconstruction and development, the inter-American development bank, the African development bank, or the Asian development bank; but the aggregate value of all bonds and other evidences of indebtedness which may be admitted assets pursuant to this paragraph (j) shall not exceed five percent of the domestic insurance company's admitted assets.

(2) A domestic insurance company may invest in mortgage-backed securities, including collateralized mortgage obligations and other obligations for the payment of money secured by participation certificates or loans secured, directly or indirectly, by real estate mortgages or deeds of trust if:

(a) The obligation or each participation certificate or loan is fully guaranteed or insured as to principal and interest by the United States or by any state, territory, or district thereof, or by any agency, instrumentality, or political subdivision of one or more of the foregoing; but the aggregate value of any one issue of such obligations which may be admitted assets pursuant to this paragraph (a) shall not exceed five percent of the domestic insurance company's admitted assets; or

(b) The obligations have received a "1" or "2" quality designation by the securities valuation office of the national association of insurance commissioners as set forth in its most recently published valuations of securities manual or are rated investment grade in Standard & Poor's (at least BBB-) or Moody's (at least Baa3) bond guides, or have received comparable designations or ratings in the event the method of presenting such designations or ratings later changes or such designations or ratings are provided by successor entities, or have received comparable investment grade designations or ratings by any similar organization approved by the commissioner; but the aggregate value of any one issue of such obligations which may be admitted assets pursuant to this paragraph (b) shall not exceed three percent of the domestic insurance company's admitted assets.

Source: L. 69: p. 492, § 5. **C.R.S. 1963:** § 72-2-21. **L. 75:** (1)(e) amended, p. 335, § 1, effective July 1. **L. 81:** (1)(e) amended and (1)(g) repealed, pp. 527, 531, §§ 2, 11, effective July 1. **L. 86:** IP(1) amended, p. 560, § 1, effective April 3. **L. 91:** (1) amended and (2) added, p. 1174, § 1, effective May 18. **L. 92:** (1)(e) and (1)(i) amended, p. 1767, § 4, effective March 20. **L. 2000:** (1)(h) and (1)(i) amended, p. 1729, § 2, effective August 15. **L. 2020:** IP(1), (1)(a), (1)(d), (1)(e), and IP(2) amended, (HB 20-1136), ch. 87, p. 347, § 1, effective September 14.

10-3-215.5. Investments in medium- and lower-grade obligations. (1) As used in this section, unless the context otherwise requires:

(a) "Aggregate amount of medium-grade and lower-grade obligations" means the aggregate statutory statement value of medium-grade and lower-grade obligations.

(a.3) "Domestic obligation" means an obligation described in section 10-3-215 (1)(a) to (1)(f).

(a.7) "Foreign obligation" means an obligation described in section 10-3-215 (1)(h) and (1)(i).

(b) "Lower-grade obligation" means an obligation rated four, five, or six by the securities valuation office of the national association of insurance commissioners or by any successor entity.

(c) "Medium-grade obligation" means an obligation rated three by the securities valuation office of the national association of insurance commissioners or by any successor entity.

(d) "Obligation" means a bond or other type of evidence of indebtedness referred to in section 10-3-215.

(2) Without the written approval of the commissioner, no domestic insurance company shall acquire, directly or indirectly, any medium-grade or lower-grade obligation of any institution if, at the time of acquisition, after giving effect to any such acquisition:

(a) The aggregate amount of all medium-grade and lower-grade domestic and foreign obligations then held by the domestic insurance company would exceed twenty percent of its admitted assets with the aggregate amount of such foreign obligations being no more than ten percent of its admitted assets; or

(b) The aggregate amount of all lower-grade domestic and foreign obligations then held by the domestic insurance company would exceed ten percent of its admitted assets with the aggregate amount of such foreign obligations being no more than five percent of its admitted assets; or

(c) The aggregate amount of all domestic and foreign obligations held by the domestic insurance company which were rated five or six by the securities valuation office of the national association of insurance commissioners or by any successor entity would exceed three percent of its admitted assets with the aggregate amount of such foreign obligations being no more than one and one-half percent of its admitted assets; or

(d) The aggregate amount of all domestic and foreign obligations held by the domestic insurance company which were rated six by the securities valuation office of the national association of insurance commissioners or by any successor entity would exceed one percent of its admitted assets with the aggregate amount of such foreign obligations being no more than one-half percent of its admitted assets.

(3) Attaining or exceeding the limit of any one of the categories listed in paragraphs (a) to (d) of subsection (2) of this section shall not preclude an insurer from acquiring obligations in other categories subject to the specific and multi-category limits.

(4) Without the written approval of the commissioner, no domestic insurance company shall acquire, directly or indirectly, any medium-grade or lower-grade obligation of any institution if, at the time of acquisition, after giving effect to any such acquisition:

(a) The aggregate amount of all medium-grade and lower-grade obligations issued, guaranteed, or insured by such institution and held by the domestic insurance company exceeds one percent of the domestic insurance company's admitted assets; or

(b) The aggregate amount of all lower-grade obligations issued, guaranteed, or insured by such institution and held by the domestic insurance company exceeds one-half of one percent of the domestic insurance company's admitted assets.

(5) Nothing contained in this section shall prohibit a domestic insurance company from acquiring any obligation which it has committed to acquire if such insurance company would have been permitted to acquire that obligation pursuant to this section on the date on which such insurance company committed to purchase that obligation; and nothing in this section shall require a domestic insurance company to sell or otherwise dispose of any investment.

(6) Notwithstanding any other provision of this section, a domestic insurance company may acquire, whether or not through a restructuring, an obligation of an institution in which such insurance company already has one or more obligations, if such obligation is acquired in order to protect an investment previously made in the obligations of such institution so long as all such acquired obligations of an institution do not exceed one-half of one percent of the insurer's admitted assets.

(7) Nothing contained in this section shall prohibit a domestic insurance company from acquiring an obligation as a result of a restructuring of a medium- or lower-grade obligation already held.

(8) The board of directors of any domestic insurance company which acquires or invests, directly or indirectly, more than two percent of its admitted assets in medium-grade and lower-grade obligations shall adopt a written plan for the acquisition of such investments. The plan, in addition to guidelines with respect to the quality of the issues invested in, shall contain appropriate diversification standards applied to all of its investments, which may include, for example, standards for issuer, industry, duration, liquidity, and geographic location.

(9) All obligations acquired by a domestic insurance company shall be rated in accordance with the standards of the securities valuation office or any successor entity.

(10) The provisions of this section shall take effect July 1, 1992, and shall apply to all investments in obligations acquired on or after that date.

Source: L. 92: Entire section added, p. 1768, § 5, effective July 1. **L. 2000:** (1)(a.3) and (1)(a.7) added and (2) amended, p. 1731, §§ 3, 4, effective August 15.

10-3-216. Mortgage loans. (1) A domestic insurance company may acquire, either directly or indirectly, obligations secured by mortgages on real estate located in the United States or Canada, but the company shall not acquire a mortgage loan that is not secured by a first lien unless the company is the holder of the first lien. Authority to acquire a mortgage loan is subject to the following:

(a) (I) At the time of acquisition, no such loan shall exceed:

(A) Ninety percent of the value of the real property if the mortgage loan is secured by a purchase-money mortgage or like security received by the insurer upon disposition of the real property;

(B) Eighty percent of the value of the real property if the mortgage loan is secured by commercial real property or by real property that is improved with a residential building designed for occupancy by five or more dwelling units and if the mortgage loan: Requires immediate scheduled payment in periodic installments of principal and interest; has an amortization period of thirty years or less; and requires periodic payments to be made no less frequently than annually. In addition, each periodic payment must be sufficient to assure that, at all times, the outstanding principal balance of the mortgage loan does not exceed the outstanding principal balance that would be outstanding under a mortgage loan with the same original

principal balance, with the same interest rate, and requiring equal payments of principal and interest with the same frequency over the same amortization period. Mortgage loans permitted under this sub-subparagraph (B) are permitted notwithstanding the fact that they provide for a payment of the principal balance prior to the end of the period of amortization of the loan. If the loan meets all other requirements of this sub-subparagraph (B), acceptable private mortgage insurance has been obtained, and the mortgage loan is secured by real property that is improved with a residential building, including a condominium, designed for occupancy by not more than four dwelling units, the loan may be up to ninety-seven percent of the value of the real property.

(C) Seventy-five percent of the value of the real property if the mortgage loan is secured by a mortgage that does not meet the requirements set forth in sub-subparagraph (A) or (B) of this subparagraph (I).

(II) In all cases, value must be evidenced by the written appraisal of a qualified real estate appraiser, who may be an employee of the company; except that, in the case of property used for the production of oil, of gas, or of other minerals, the appraisal must be made by an engineer or geologist qualified in the relevant field. For commercial properties of over one hundred thousand dollars in value, the appraiser must be a member of an institute of real estate appraisers, or its equivalent.

(b) and (c) Repealed.

(d) Any improvements must be insured against casualty loss, for the benefit of the lending company, by a reliable property and casualty insurance company for an amount not less than the unpaid balance of the obligation or the insurable value of the property, whichever is less.

(e) The company must hold the documents necessary to evidence the company's ownership of the company's liens. If, under the law of the jurisdiction where the real property is situated, it is necessary to the validity of the lien to record a mortgage or assignment of the lien, the company must record the mortgage or assignment in compliance with such law.

(f) The entire mortgage loan obligation must be owned by the company; except that the company may own this type of obligation in common with other participants if, at the time of the company's investment, each participant is:

(I) A bank whose depositors are insured by the federal deposit insurance corporation;

(II) A savings and loan association whose members are insured by the federal deposit insurance corporation or any successor agency thereto;

(III) A trust for a pension or other benefit plan for employees qualified under section 401 of the federal "Internal Revenue Code of 1986", as amended;

(IV) An insurance company organized in any state of the United States, the District of Columbia, or any province of Canada; or

(V) A corporation or association owned wholly by one or more of the entities or one or more wholly owned subsidiaries of the entities specified in subparagraph (I), (II), or (IV) of this paragraph (f).

(g) Repealed.

(h) If before a loan is paid the value of the real property, including any improvements thereon, securing the loan depreciates, the loan may nevertheless be carried as an admitted asset, but not for an amount exceeding seventy-five percent of the current value of the real property.

(i) The maximum amount of a loan made, directly or indirectly, to any one obligor that may be an admitted asset of the company under this section must not exceed two percent of the company's admitted assets.

(j) The aggregate amount of investments of a company that may be admitted assets under this section must not exceed fifty percent of the company's admitted assets.

(2) (a) A domestic insurance company may acquire a mortgage loan secured by a mortgage on real estate located in a foreign jurisdiction having a sovereign debt rating of "1" from the securities valuation office of the National Association of Insurance Commissioners if the mortgage loan otherwise meets the requirements of subsection (1) of this section; except that the aggregate amount of foreign mortgage loans that may be admitted assets under this subsection (2)(a) must not exceed ten percent of the company's admitted assets.

(b) This subsection (2) does not apply to a jurisdiction described in subsection (1) of this section.

Source: L. 69: p. 492, § 5. **C.R.S. 1963:** § 72-2-22. **L. 71:** p. 708, § 1. **L. 73:** pp. 839, 840, §§ 1, 2. **L. 75:** (1)(j) amended, p. 339, § 1, effective June 26; (1)(f) R&RE, p. 335, § 2, effective July 1. **L. 81:** (1)(a) amended, p. 532, § 1, effective April 1; (1)(f) and (1)(j) amended, p. 528, § 3, effective July 1. **L. 93:** (1)(f)(II) amended, p. 1772, § 25, effective June 6; (1)(i) and (1)(j) amended, p. 574, § 2, effective July 1. **L. 2000:** (1)(f)(III) amended, p. 1839, § 7, effective August 2. **L. 2004:** (1)(f)(II) amended, p. 148, § 51, effective July 1. **L. 2014:** IP(1), (1)(a), and (1)(e) amended and (1)(b) and (1)(g) repealed, (SB 14-209), ch. 396, p. 1995, § 1, effective August 6. **L. 2020:** IP(1), (1)(a)(II), (1)(d), (1)(e), IP(1)(f), (1)(i), and (1)(j) amended, (1)(c) repealed, and (2) added, (HB 20-1136), ch. 87, p. 348, § 2, effective September 14.

10-3-217. Federally guaranteed or insured real estate loans. Domestic insurance companies may invest in obligations for the payment of money secured by real estate mortgages or deeds of trust which are either guaranteed or insured by the United States, any state, territory, or district thereof, or by any agency, instrumentality, or political subdivision of one or more of the foregoing, if any such investment which is in excess of the value limitation set forth in section 10-3-216 (1)(a) is so insured or guaranteed.

Source: L. 69: p. 494, § 5. **C.R.S. 1963:** § 72-2-23.

10-3-218. Real estate for use in company's business. Domestic insurance companies may invest in real estate for the accommodation of the company's business, but the aggregate investments by a company that may be admitted assets under this section shall not exceed fifteen percent of the company's admitted assets unless the commissioner has given prior approval of a greater aggregate investment. Any space in the company's home office building that is not required for its use may be rented to others. The commissioner may approve investments under this section which in the aggregate will not exceed twenty percent of the company's admitted assets, upon a finding that such investments do not render the company's operation hazardous, or its condition unsound, to the public or its policyholders.

Source: L. 69: p. 494, § 5. **C.R.S. 1963:** § 72-2-24. **L. 81:** Entire section amended, p. 529, § 4, effective July 1. **L. 2001:** Entire section amended, p. 280, § 3, effective March 30.

10-3-219. Real estate acquired in satisfaction of indebtedness. (1) The following shall be admitted assets:

(a) Such real estate as has been mortgaged to the company in good faith, by way of security for loans or for money due it;

(b) Such real estate as is conveyed to the company in good faith in satisfaction of debts previously contracted in the course of its business;

(c) Such real estate as is purchased at sales under execution issued on judgments and decrees based upon debts due, or at foreclosure sales under mortgages or deeds of trust owned or held by the company or obtained by redemption as junior judgment creditor or mortgagee.

Source: L. 69: p. 494, § 5. **C.R.S. 1963:** § 72-2-25.

10-3-220. Real estate for production of income - definition. (1) A domestic insurance company may invest in real estate for the production of income, subject to the following provisions:

(a) The aggregate investments by a company which may be admitted assets under this section shall not exceed ten percent of the company's admitted assets.

(b) The investment in any single parcel of real estate which may be an admitted asset under this section shall not exceed five percent of the company's admitted assets.

(c) Real estate qualifying as an admitted asset under section 10-3-218 or 10-3-219 may, at the option of the company, be an admitted asset under this section if such real estate is otherwise eligible under the provisions of this section.

(2) (a) "Real estate", as used in this section, means real property; interests in real property, such as leaseholds; minerals and oil and gas that have not been severed from the fee interest; and improvements and fixtures located on or in real property.

(b) "Real estate" does not include mineral estates that have been severed from the fee interest.

Source: L. 69: p. 494, § 5. **C.R.S. 1963:** § 72-2-26. **L. 2001:** (2) amended, p. 281, § 4, effective March 30. **L. 2020:** (2) amended, (HB 20-1136), ch. 87, p. 350, § 3, effective September 14.

10-3-221. Tangible personal property for production of income. (Repealed)

Source: L. 69: p. 494, § 5. **C.R.S. 1963:** § 72-2-27. **L. 2001:** (1) repealed, p. 281, § 5, effective March 30.

10-3-222. Policy loans. (Repealed)

Source: L. 69: p. 495, § 5. **C.R.S. 1963:** § 72-2-28. **L. 71:** p. 709, § 1. **L. 2001:** Entire section repealed, p. 281, § 6, effective March 30.

10-3-223. Accounts in building or savings and loan associations. (Repealed)

Source: L. 69: p. 495, § 5. **C.R.S. 1963:** § 72-2-29. **L. 77:** Entire section amended, p. 456, § 3, effective July 1. **L. 2001:** Entire section repealed, p. 281, § 7, effective March 30.

10-3-224. Time deposits. (Repealed)

Source: L. 69: p. 495, § 5. **C.R.S. 1963:** § 72-2-30. **L. 88:** Entire section amended, p. 401, § 1, effective March 24. **L. 2001:** Entire section repealed, p. 282, § 8, effective March 30.

10-3-225. Transportation equipment interests. Domestic insurance companies may invest in equipment trust obligations or certificates which are adequately secured, or in other adequately secured instruments evidencing an interest in transportation equipment wholly or in part within the United States, and the right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of such transportation equipment; but the aggregate investments by a company which may be admitted assets under this section shall not exceed ten percent of the company's admitted assets, and the investment in the obligations or certificates of or in relation to any one transportation company, which may be admitted assets under this section, shall not exceed two percent of the investing company's admitted assets.

Source: L. 69: p. 495, § 5. **C.R.S. 1963:** § 72-2-31.

10-3-226. Equity interests - definition. (1) A domestic insurance company may invest in equity interests in business entities created under the laws of the United States, of a state of the United States or the District of Columbia, or of Canada or any province of Canada, but the aggregate value of all equity interests that may be admitted assets under this section must not exceed ten percent of the company's admitted assets. For the purpose of this limitation on aggregate value, a company may determine the value of all its equity interests that may be admitted assets under this section on the basis of the aggregate initial cost of the equity interests in lieu of determining the value of all of the equity interests as provided in section 10-3-214.

(2) Notwithstanding the provisions of subsection (1) of this section, a domestic fire, casualty, or multiple-line insurance company may invest an additional twenty-five percent of its admitted assets in preferred and common stocks of any corporation organized under the laws of the United States, any state, territory, or possession of the United States, the District of Columbia, or the Dominion of Canada or any province thereof.

(3) Investments authorized by subsections (1) and (2) of this section are subject to the following restrictions at the time of investment:

(a) and (b) Repealed.

(c) If there is a rise in the market value of the aggregate stock investments of a domestic insurance company and if the current market value of the aggregate investments of such company in common and preferred stock exceeds fifty percent of the admitted assets of such company as valued on December 31 of any year, then such company shall, on or before March 1 of the following year, liquidate a portion of such investments so that the market value of such stock investments does not exceed fifty percent of the company's admitted assets.

(d) (I) Investments in common stock in any one corporation, at the time of investment, must not exceed two percent of the admitted assets of the investing insurance company, and, at

the time of investment, an insurance company shall not purchase more than five percent of the outstanding shares of common stock of any one corporation.

(II) This subsection (3)(d) does not apply to investments in mutual funds, open-end index funds, or exchange-traded index funds.

(e) This section shall not apply to investments made pursuant to the provisions of section 10-3-802.

(f) Investments in equity interests that are not listed on a nationally registered securities exchange or a securities market regulated under the "Securities Exchange Act of 1934", 15 U.S.C. sec. 78a et seq., as amended, must not exceed five percent of the admitted assets of the investing company.

(4) As used in this section, "equity interest" means:

(a) Common stock;

(b) Preferred stock;

(c) A trust certificate;

(d) Equity investments in an investment company other than a qualified money market fund, as defined in section 10-3-242 (1);

(e) Investments in a common trust fund of a bank regulated by a federal or state agency;

(f) An ownership interest in a mineral estate that has been severed from the fee interest;

(g) Instruments that are or must be, at the option of the issuer, convertible to equity;

(h) Partnership interests;

(i) Membership interests in limited liability companies;

(j) Investments in mutual funds, other than qualified money market funds as defined in section 10-3-242 (1); or

(k) Investments in open-end index funds or exchange-traded index funds.

(5) (a) A domestic insurance company may invest in equity interests in business entities created under the laws of a foreign jurisdiction having a sovereign debt rating of "1" from the securities valuation office of the National Association of Insurance Commissioners if the equity interests otherwise meet the requirements of subsections (1) to (3) of this section; except that the aggregate amount of the foreign equity interests that may be admitted assets under this subsection (5)(a) must not exceed three percent of the company's admitted assets.

(b) This subsection (5) does not apply to a jurisdiction described in subsection (1) of this section.

Source: L. 69: p. 495, § 5. **C.R.S. 1963:** § 72-2-32. **L. 71:** p. 755, § 2. **L. 73:** pp. 842, 1408, §§ 1, 52, 53. **L. 75:** Entire section R&RE, p. 336, § 3, effective July 1. **L. 81:** (3)(a) and (3)(b) amended, p. 529, § 5, effective July 1. **L. 2020:** (1), IP(3), and (3)(d) amended, (3)(a) and (3)(b) repealed, and (3)(f), (4), and (5) added, (HB 20-1136), ch. 87, p. 350, § 4, effective September 14.

10-3-227. Stock for purpose of reinsurance, consolidation, or merger. (1) Domestic insurance companies may invest in stock in any other insurance company authorized to do a similar business to that of the investing company, subject to the following provisions:

(a) No greater amount shall be applied to the acquisition of such stock than the investing company's capital and surplus in excess of the minimum required by law; except that, the

commissioner may, by written order prior to such acquisition, permit the application of a greater amount thereto.

(b) A reinsurance, consolidation, or merger between the investing company and such other insurance company shall be effected within two years of the acquisition of such stock or within such extension of such period as may be granted by the commissioner.

Source: L. 69: p. 496, § 5. **C.R.S. 1963:** § 72-2-34.

10-3-228. Collateral loans. (1) Domestic insurance companies may invest in collateral loans secured by the pledge of any one or more investments allowed for collateral loans, as provided by nationally recognized insurance statutory accounting principles, subject to the following provisions:

(a) The collateral pledged shall be legally assignable and validly assigned to the lending company.

(b) As at date made, no such loan shall exceed in amount seventy-five percent of the value of the collateral pledged.

(c) At no time shall the admitted value of a collateral loan be in excess of the actual market value of the collateral pledged.

(d) If any of the collateral pledged and taken into account to qualify a loan as an admitted asset under this section is of a category which, if invested in directly, would be subject to a limitation expressed as a percentage of the investing company's admitted assets, then, for the purpose of such limitation, so much of the loan as is so qualified by such collateral will be deemed to be a direct investment in such category.

(e) No loan shall qualify as an admitted asset under this section unless limited to a term not exceeding five years or, if less, the maturity date, if any, of any of the collateral taken into account in qualifying the loan as an admitted asset under this section.

Source: L. 69: p. 496, § 5. **C.R.S. 1963:** § 72-2-35. **L. 2002:** IP(1) amended, p. 1012, § 5, effective June 1. **L. 2004:** IP(1) amended, p. 1063, § 10, effective July 1.

10-3-228.5. Securities lending - repurchase - reverse repurchase - dollar roll transactions. (1) For the purposes of this section, unless the context otherwise requires:

(a) "Dollar roll transaction" means two simultaneous transactions with settlement dates no more than ninety-six days apart so that in one transaction an insurer sells to a business entity and in the other transaction the insurer is obligated to purchase, from the same business entity, substantially similar securities of the following types:

(I) Mortgage-backed securities issued, assumed, or guaranteed by the government national mortgage association, the federal national mortgage association, the federal home loan mortgage corporation, or their respective successors; and

(II) Other mortgage-backed securities referred to in section 106 of Title I of the "Secondary Mortgage Market Enhancement Act of 1984", 15 U.S.C. sec. 77r-1, as amended.

(b) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

(c) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(d) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

(2) An insurer may engage in securities lending, repurchase, reverse repurchase, and dollar roll transactions as set forth in this section. The insurer shall enter into a written agreement for securities lending, repurchase, reverse repurchase, and dollar roll transactions. Such agreements shall require that each transaction terminate no more than one year from its inception.

(3) Cash received in a transaction under this section shall be invested in accordance with this article and in a manner that recognizes the liquidity needs of the transaction or is used by the insurer for its general corporate purposes.

(4) So long as the transaction remains outstanding, the insurer, or its agent or custodian, shall maintain as acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the federal reserve, depository trust company, participants' trust company, or other securities depositories approved by the commissioner, any of the following:

(a) Possession of the acceptable collateral;

(b) A perfected security interest in the acceptable collateral; or

(c) In the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the acceptable collateral.

(5) The limitations of section 10-3-215 (1)(e) and section 10-3-215.5 shall not apply to the business entity counter-party exposure created by transactions under this section. An insurer shall not enter into a transaction under this section, other than a dollar roll transaction, if, as a result of and after giving effect to the transaction:

(a) The aggregate amount of securities then loaned, sold to, or purchased from any one business entity counter-party under this section would exceed five percent of its admitted assets; and in calculating the amount sold to or purchased from a business entity counter-party under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

(b) The aggregate amount of all securities then loaned, sold to, or purchased from all business entities under this section would exceed forty percent of its admitted assets.

(6) The amount of collateral required for securities lending, repurchase, and reverse repurchase transactions is the amount required pursuant to the provisions of the purposes and procedures manual of the national association of insurance commissioners' securities valuation office or pursuant to a successor to such publication.

Source: L. 2001: Entire section added, p. 282, § 9, effective March 30.

10-3-229. Investments for purposes of compliance in other jurisdictions. Admitted assets shall consist of such other securities and investments as may be necessary to comply with

the laws or the departmental rules of other states or nations in which the company may do business.

Source: L. 69: p. 497, § 5. **C.R.S. 1963:** § 72-2-36.

10-3-230. Additional investments. (1) A domestic insurance company may invest in any additional investments, except items specifically defined as nonadmitted assets in this title 10, other than article 15 of this title 10, and article 14 of title 24, without regard to any limitation, condition, restriction, or exclusion set forth in sections 10-3-215 to 10-3-229 and 10-3-242, and regardless of whether the same or a similar type of investment has been included in or omitted from these sections, subject to the following:

(a) The total amount of indebtedness secured by a lien on any single parcel of real property is an admitted asset only to the extent that such indebtedness does not exceed the value limitation set forth in section 10-3-216 (1)(a).

(a.1) Notwithstanding the provisions of paragraph (a) of this subsection (1), indebtedness, subject to the provisions of section 10-3-216 (1)(h), is an admitted asset only to the extent that such indebtedness does not exceed ninety-five percent of the current value of the real property. The aggregate investment by a company which may be admitted assets under this paragraph (a.1) shall not exceed twenty percent of the limits allowable under paragraph (c) of this subsection (1).

(b) The amount of indebtedness secured by a pledge of any collateral shall be an admitted asset only to the extent that such indebtedness does not exceed the value limitation set forth in section 10-3-228 (1)(b).

(c) The aggregate investments by a company which may be admitted assets under this section shall not exceed the lesser of five percent of its admitted assets or fifty percent of the amount by which the sum of the par value of its outstanding capital stock, if any, and its surplus exceeds the sum of the minimum capital, if any, and the minimum surplus required of such company under the applicable provision of section 10-3-201.

(d) The admitted asset value of investments in mortgage loans must not exceed the value limitations as set forth in section 10-3-216 (1)(i), (1)(j), and (2).

Source: L. 69: p. 497, § 5. **C.R.S. 1963:** § 72-2-37. **L. 70:** p. 120, § 17. **L. 71:** p. 710, § 1. **L. 81:** IP(1) amended, p. 530, § 6, effective July 1. **L. 85:** IP(1) amended, p. 380, § 3, effective May 1. **L. 92:** IP(1) amended, p. 1550, § 42, effective May 20. **L. 93:** (1)(a.1) and (1)(d) added, p. 573, § 1, effective July 1. **L. 2002:** IP(1) amended, p. 1012, § 6, effective June 1. **L. 2004:** IP(1) amended, p. 1063, § 11, effective July 1. **L. 2012:** IP(1) amended, (HB 12-1266), ch. 280, p. 1506, § 31, effective July 1. **L. 2020:** IP(1) and (1)(d) amended, (HB 20-1136), ch. 87, p. 352, § 5, effective September 14.

10-3-231. Valuation of investments. (1) (a) Subject to the provisions of paragraphs (b), (c), and (d) of this subsection (1), all obligations having a fixed term and rate may, if not in default as to principal or interest, be valued as follows: If purchased at par, at the par value; if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made.

(b) The purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus brokerage charges paid in the acquisition of such obligations.

(c) No such obligation shall be carried at above the call price for the entire issue during any period within which the obligation may be so called, and premiums paid at purchase shall be amortized by the scientific method to the first call date at which the entire issue may be redeemed.

(d) Obligations subject to amortization under the published findings of the national association of insurance commissioners shall be carried at their amortized values. Obligations which do not qualify for amortization shall be reported at their market value or a book value based on an amortized computation, whichever is lower.

(2) (a) Common stocks shall be valued at their market value, as determined by customary method, or, at the option of the company, they may be carried at cost if cost is less than market value. If no publicly traded market quotation is available, the value of the stocks shall be based on the pro rata share of the issuing company's net worth as shown by its audited financial statement or, in the case of an insurance company, the pro rata share of its statutory net worth.

(b) Preferred stocks shall be valued in accordance with procedures promulgated annually by the valuations committee of the national association of insurance commissioners.

(3) Other property purchased by a company may be valued at not more than its cost plus the cost of capitalized additions and permanent improvements, less depreciation. Depreciation shall be computed under the straight line method or, at the option of the company, under any other method resulting in larger accumulated depreciation at any given time. Depreciation of any buildings shall be based upon an estimated useful life of not more than fifty years.

(4) Property acquired in satisfaction of a debt shall be valued at its fair market value or the amount of the debt, including capitalized taxes and expenses, whichever amount is less.

(5) Property originally acquired in satisfaction of a debt and subsequently transferred to qualification under section 10-3-220 or 10-3-230 shall be valued as provided in subsection (3) of this section, and its cost shall be deemed to be its value at time of transfer determined under subsection (4) of this section.

(6) To the extent investments are valued by the securities valuation office of the national association of insurance commissioners, all investments owned by domestic insurance companies shall be valued in accordance with the most recently published valuations of the securities valuation office. Other investments not valued by the securities valuation office shall be valued as otherwise is provided in this section, or, if not otherwise provided in this section, in accordance with procedures promulgated by the national association of insurance commissioners.

Source: L. 69: p. 497, § 5. **C.R.S. 1963:** § 72-2-38. **L. 71:** p. 711, § 1. **L. 81:** (2)(a) amended, p. 530, § 7, effective July 1. **L. 91:** (6) added, p. 1247, § 8, effective July 1.

10-3-232. Liens for certain purposes permitted. For the purposes of section 10-3-216, the existence of any lien existing by law, for the payment of any bonds, indebtedness, or assessments of, or created by a levy of, any special improvement district, any tunnel district, any conservation district, any irrigation district, any other district or territory, any municipality or quasi-municipality, or any state in which any real estate is situated, or by the United States, shall

not prevent mortgages, trust deeds, or other encumbrances upon such real estate, if otherwise first liens, from being admitted assets of domestic insurance companies, if the property securing such mortgage, deed of trust, or other encumbrance is not delinquent in the payment of any installment or interest upon any such bonds, indebtedness, or assessments at the time such real estate loan is made.

Source: L. 69: p. 498, § 5. **C.R.S. 1963:** § 72-2-39.

10-3-233. Disposition of certain real estate. Any parcel of real estate qualifying as an admitted asset under section 10-3-218 or 10-3-219 at the time of its acquisition by the company and which has not been transferred to qualification as an admitted asset under any other section of this part 2 shall be sold within five years after such acquisition or within five years after its use for the accommodation of the company's business has entirely ceased, whichever is later, unless the company procures a certificate from the commissioner that the company's interests will suffer by such a sale, in which event the time may be extended as the commissioner shall direct in such certificate.

Source: L. 69: p. 498, § 5. **C.R.S. 1963:** § 72-2-40. **L. 81:** Entire section amended, p. 530, § 8, effective July 1.

10-3-234. Approval and record of investments. (1) No investment, loan, or sale thereof shall, except as to loans on a life insurance company's policies or annuity and supplementary contracts, be made by any domestic insurance company:

(a) Without the advance approval of its board of directors or of a committee appointed by such board and charged with the duty of making such investments, loans, or sales or of an officer charged with such duty; or

(b) Unless the transaction is:

(I) Transacted in compliance with a written policy or plan approved by its board of directors prior to the transaction; and

(II) Ratified by such board or by a committee appointed by such board charged with the duty of reviewing such investments, loans, and sales at a meeting held not less than quarterly.

(2) A permanent written record of all such investments, loans, and sales shall be maintained by the company.

Source: L. 69: p. 498, § 5. **C.R.S. 1963:** § 72-2-41. **L. 2000:** Entire section amended, p. 445, § 1, effective August 2.

10-3-235. Certain admitted assets deemed securities for deposit purposes. (1) For purposes of the minimum capital or guaranty fund deposit required by section 10-3-201, the following admitted assets shall be deemed to be securities eligible for such deposit: Any asset qualified as an admitted asset under sections 10-3-215 to 10-3-217 and 10-3-225.

(2) For purposes of optional reserve deposits permitted by section 10-7-101 (3) or other deposits permitted but not required by this title (except article 15) and article 14 of title 24, C.R.S., the following admitted assets, in addition to those referred to in subsection (1) of this section, shall be deemed to be securities eligible for such deposits: Any asset qualified as an

admitted asset under section 10-3-220 or 10-3-226 to 10-3-228, and any life insurance policy, to the extent of the company's interest in the cash value thereof.

(3) If a company deposits the stock of a wholly owned insurance subsidiary with the commissioner as an optional reserve deposit, the value of such stock for purposes of such deposit shall be reduced by the value of any cash or securities owned by the subsidiary and on deposit with the commissioner or with the duly authorized officer in any other jurisdiction as a deposit of the subsidiary required or permitted by law.

(4) For purposes of all deposits required or permitted by this title (except article 15) and article 14 of title 24, C.R.S., assets shall be valued at their fair market value; except that, for purposes of optional reserve deposits permitted by section 10-7-101 (3), or other deposits permitted but not required by said references, bonds and mortgages shall be valued at their current book values under the methods used in determining admitted asset values for annual statement purposes.

Source: L. 69: p. 499, § 5. **C.R.S. 1963:** § 72-2-42. **L. 92:** (2) and (4) amended, p. 1550, § 43, effective May 20. **L. 2002:** (1) and (2) amended, p. 1013, § 7, effective June 1. **L. 2004:** (2) and (4) amended, p. 901, § 18, effective May 21. **L. 2012:** (2) and (4) amended, (HB 12-1266), ch. 280, p. 1506, § 32, effective July 1.

10-3-236. Assets acquired through merger, consolidation, or reinsurance. Any investments acquired through merger, consolidation, or reinsurance that are not admitted assets under this title 10, other than article 15 of this title 10, and article 14 of title 24 are not deemed admitted assets by reason of their acquisition through merger, consolidation, or reinsurance.

Source: L. 69: p. 499, § 5. **C.R.S. 1963:** § 72-2-43. **L. 92:** Entire section amended, p. 1551, § 44, effective May 20. **L. 2004:** Entire section amended, p. 902, § 19, effective May 21. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1506, § 33, effective July 1. **L. 2020:** Entire section amended, (HB 20-1136), ch. 87, p. 352, § 6, effective September 14.

10-3-237. Assets acquired under prior law. (1) Notwithstanding any condition, restriction, or exclusion set forth in sections 10-3-215 to 10-3-229, any asset held by a domestic insurance company on May 31, 1969, that met the requirements of the law in effect immediately prior to that date for an investment of the company's reserves, paid-up capital stock, and other liabilities is an admitted asset of the company, but, if any such asset is in a category for which a limitation expressed in terms of a percentage of admitted assets is prescribed in section 10-3-218, 10-3-220, 10-3-225, or 10-3-226, the asset shall be taken into account in determining whether any additional investment in that category made after May 31, 1969, may be an admitted asset under the section prescribing the limitation.

(2) Notwithstanding any other provision of this title (except article 15) and article 14 of title 24, C.R.S., any asset held by a company on May 31, 1969, that is not an admitted asset under section 10-1-102 (2) or subsection (1) of this section and that did not meet the requirements of the law in effect immediately prior to such date for an investment of the company's reserves, paid-up capital stock, and other liabilities but which, under such law, would have been taken into account as an asset in determining the surplus of the company shall be taken into account as an admitted asset at all times at which the company has aggregate admitted

assets under section 10-1-102 (2) and subsection (1) of this section in an amount at least equal to the total of its reserves, paid-up capital stock, and all other liabilities.

(3) Notwithstanding any condition, restriction, or exclusion set forth in section 10-3-215 (1)(e), 10-3-216 (1)(f), or 10-3-226, any asset held prior to July 1, 1975, or thereafter acquired by exercise of warrants or other rights which were held prior to that date which met or would have met the requirements of the law in effect immediately prior to July 1, 1975, for an investment of the company's reserves, paid-up stock, and other liabilities shall be an admitted asset of the company; but, if any such asset is in a category for which a limitation expressed in terms of a percentage of admitted assets is prescribed in such sections, such asset shall be taken into account in determining whether any additional investment in such category made after July 1, 1975, may be an admitted asset under the section prescribing such limitation.

(4) Notwithstanding any condition, restriction, or exclusion set forth in section 10-3-218, any asset held by a company on July 1, 1981, which met the requirements of the law in effect immediately prior to such date for an investment of the company qualified as an admitted asset under this part 2 shall remain an admitted asset; but such asset shall be taken into account in determining whether any additional investment made on or after July 1, 1981, may be an admitted asset under this part 2.

Source: L. 69: p. 499, § 5. **C.R.S. 1963:** § 72-2-44. **L. 75:** (3) added, p. 337, § 4, effective July 1. **L. 81:** (4) added, p. 530, § 9, effective July 1. **L. 92:** (2) amended, p. 1551, § 45, effective May 20. **L. 2002:** (2) amended, p. 1013, § 8, effective June 1. **L. 2003:** (2) amended, p. 616, § 10, effective July 1. **L. 2004:** (2) amended, p. 1063, § 12, effective July 1. **L. 2012:** (2) amended, (HB 12-1266), ch. 280, p. 1506, § 34, effective July 1. **L. 2020:** (1) amended, (HB 20-1136), ch. 87, p. 352, § 7, effective September 14.

10-3-238. Refunds. Whenever it appears to the satisfaction of the commissioner that, because of some mistake of fact, error in calculation, or erroneous interpretation of a statute of this or any other state, any insurer or other person engaged in the business of insurance in this state has paid to the commissioner or to the state of Colorado, pursuant to any provision of this title (except article 15) and article 14 of title 24, C.R.S., any taxes, fees, or other charges in excess of the amount legally chargeable against said insurer or other person during the one-year period immediately preceding the discovery of such overpayment, the commissioner has the authority to refund to such insurer or other person the amount of such excess by applying the amount thereof toward the payment of taxes, fees, or other charges already due, or that may thereafter become due, from such insurer or other person until such excess has been fully refunded; or, at the commissioner's discretion, the commissioner may make a cash refund thereof.

Source: L. 71: p. 704, § 1. **C.R.S. 1963:** § 72-1-63. **L. 92:** Entire section amended, p. 1551, § 46, effective May 20. **L. 2004:** Entire section amended, p. 902, § 20, effective May 21. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1507, § 35, effective July 1.

10-3-239. Subordinated indebtedness. Domestic insurance companies may borrow and thereby assume a liability for the repayment of a sum of money upon a written agreement that the loan or advance with interest shall be repaid only out of surplus of the company in excess of

such minimum surplus as is stipulated in and by the agreement. The agreement shall first be submitted to and approved by the commissioner. Repayment of principal or payment of interest may be made only with the approval of the commissioner when he is satisfied that the financial condition of the company warrants such action, but such approval may not be withheld if the company has and submits satisfactory evidence of surplus of not less than the amount stipulated in the repayment of principal or interest clause of the agreement. No loan or advance made under the provisions of this section or interest accruing thereon shall form a part of the legal liabilities of the company until authorized for payment by the commissioner, but, until such authorization, all statements published by the company or filed with the commissioner shall show the amount thereof then remaining as a special surplus account. Nothing in this section shall be construed to mean that a company may not otherwise borrow money, but the amount so borrowed with accrued interest thereon shall be carried by the company as a liability.

Source: L. 73: p. 837, § 1. **C.R.S. 1963:** § 72-1-66.

Cross references: For financial statements that must be filed, see § 10-3-208.

10-3-240. Approval of investments. (1) Except for investments made under sections 10-3-802 and 10-7-402, a domestic insurance company shall not, directly or indirectly, invest more than two percent of the company's admitted assets in stocks, bonds, debentures, notes, or other securities of its affiliates, as defined in section 10-3-801, without the prior approval of the commissioner.

(2) Notwithstanding the provisions of subsection (1) of this section, the commissioner may, upon written notice, require a domestic insurance company to obtain his prior approval for all investments in its affiliates if, based on past transactions of the insurance company, he determines that such investments might render the company's operation hazardous, or its condition unsound, to the public or its policyholders.

(3) Any domestic insurance company proposing to make an investment subject to approval under subsection (1) or (2) of this section shall give written notice thereof to the commissioner. If the commissioner has not approved or disapproved such investment within thirty days after receipt of such notice, the investment shall be deemed approved at the end of such thirty-day period.

Source: L. 75: Entire section added, p. 337, § 5, effective July 1. **L. 2020:** (1) amended, (HB 20-1136), ch. 87, p. 353, § 8, effective September 14.

10-3-241. Prohibited investments. (Repealed)

Source: L. 81: Entire section added, p. 531, § 10, effective July 1. **L. 83:** Entire section amended, p. 453, § 1, effective April 21. **L. 2001:** Entire section repealed, p. 286, § 10, effective March 30.

10-3-242. Qualified money market funds - definition. (1) As used in this section, "qualified money market fund" means a mutual fund that complies with 17 CFR 270.2a-7, as amended, and that is registered under the federal "Investment Company Act of 1940", 15 U.S.C.

sec. 80a-1 et seq., as amended. A domestic insurance company may invest in the shares of any one or more qualified money market funds subject to the following limitations:

(a) (I) A domestic insurance company may invest in qualified money market funds that, at the time the investment is made, are either:

(A) Qualified money market funds that invest only in obligations issued, guaranteed, or insured by the federal government of the United States or in collateralized repurchase agreements composed of these obligations, and that qualify for investment without a reserve under the purposes and procedures manual of the securities valuation office of the National Association of Insurance Commissioners; or

(B) Qualified money market funds that qualify for investment using the bond class one reserve factor under the purposes and procedures manual of the securities valuation office of the National Association of Insurance Commissioners.

(II) Investments in the shares of any one qualified money market fund qualifying under this subsection (1)(a) must not exceed ten percent of the domestic insurance company's total admitted assets.

(b) Investments in shares of any one qualified money market fund not qualified under subsection (1)(a) of this section must not exceed five percent of the domestic insurance company's total admitted assets. The aggregate value of all shares that may be admitted assets under this subsection (1)(b) must not exceed ten percent of the company's total admitted assets.

(c) At the time of an investment in a qualified money market fund under this section, the aggregate value of a domestic insurance company's investment in the fund must not exceed five percent of the shares of the fund.

(2) to (4) (Deleted by amendment, L. 2000, p. 1731, § 5, effective August 15, 2000.)

Source: L. 85: Entire section added, p. 379, § 1, effective May 1. **L. 96:** (1) amended, p. 555, § 4, effective April 24. **L. 2000:** Entire section amended, p. 1731, § 5, effective August 15. **L. 2020:** (1) amended, (HB 20-1136), ch. 87, p. 353, § 9, effective September 14.

10-3-243. Derivative transactions - definitions - restrictions - rules. (1) For the purposes of this section, unless the context otherwise requires:

(a) "Counter-party exposure amount" means:

(I) The net amount of credit risk attributable to a derivative instrument entered into with a business entity other than through a qualified exchange or qualified foreign exchange, or cleared through a qualified clearinghouse as an over-the-counter derivative instrument. The net amount of credit risk shall equal:

(A) The market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(B) Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

(II) If over-the-counter derivative instruments are entered into under a written master agreement that provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counter-party is either within the United States or within a foreign jurisdiction listed in the purposes and procedures manual of the national association of insurance commissioners' securities valuation office as eligible for netting, the net amount of credit risk shall be the greater of zero or the net sum of:

(A) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer; and

(B) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

(III) For open transactions, market value shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

(b) (I) "Derivative instrument" means an agreement, option, instrument, or a series or combination thereof:

(A) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests or to make a cash settlement in lieu thereof; or

(B) That has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one or more underlying interests.

(II) (A) "Derivative instrument" includes options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, and any other agreements, options, or investments that are substantially similar and any agreements, options, and instruments permitted under rules adopted by the commissioner.

(B) "Derivative instrument" does not include investments that are otherwise permitted pursuant to this article, nor does "derivative instrument" include repurchase, reverse repurchase, dollar roll, securities lending, or similar transactions.

(c) "Hedging transaction" means a derivative transaction that is entered into and maintained to reduce or manage:

(I) The risk of a change in value, yield, price, cash flow, or quantity of assets or liabilities that an insurer has acquired or incurred or anticipates acquiring or incurring; or

(II) The currency exchange rate risk or the degree of exposure as to assets or liabilities that an insurer has acquired or incurred or anticipates acquiring or incurring.

(d) "Income generation" means a derivative transaction involving the writing of covered call options, covered put options, covered caps, or covered floors that is intended to generate income or enhance return.

(e) "Replication transaction" means a derivative transaction or combination of derivative transactions that is intended to replicate the investment in one or more assets that an insurer is authorized to acquire or sell under this title. A derivative transaction that is entered into as a hedging transaction shall not be considered a replication transaction.

(2) A domestic insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section by:

(a) Using derivative instruments to engage in hedging transactions if, as a result of and after giving effect to the transactions:

(I) The aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed seven and one-half percent of its admitted assets;

(II) The aggregate statement value of options, caps, and floors written in hedging transactions does not exceed three percent of its admitted assets; and

(III) The aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed six and one-half percent of its admitted assets;

(b) Entering into the following types of income generation transactions if, as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income or equity assets that are subject to call or that generate the cash flows for payments under the caps or floors, plus the face value of fixed income securities underlying derivative instruments subject to call, plus the amount of the purchase obligations under the puts, does not exceed ten percent of its admitted assets:

(I) Sales of covered call options on noncallable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period, or derivative instruments based on fixed income securities;

(II) Sales of covered call options on equity securities, if the insurer holds in its portfolio, or is able to immediately acquire through the exercise of options, warrants, or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold;

(III) Sales of covered puts on investments that the insurer is permitted to acquire under this section, if the insurer has placed into escrow, or entered into a custodial agreement segregating, cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put during the complete term of the put option sold; or

(IV) Sales of covered caps or floors, if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under the caps or floors during the complete term that the cap or floor is outstanding.

(c) An insurer may use derivative instruments for replication transactions if any asset being replicated is subject to all the provisions and limitations on the making thereof specified in this title with respect to investments by the insurer as if the transaction constituted a direct investment by the insurer in the replicated asset.

(d) An insurer shall include all counter-party exposure amounts in determining compliance with general diversification requirements and medium- and low-grade investment limitations under this section.

(e) Any investments in derivative investments shall be made in accordance with a written derivative use plan approved by the company's board of directors. The derivative use plan must be available for review by the commissioner upon request. An insurer must be able to demonstrate to the commissioner the intended hedging characteristics and ongoing effectiveness of the derivative transactions through cash flow testing or other appropriate analysis.

(f) The commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits in this section.

(3) Notwithstanding any provision of this section to the contrary, domestic insurers are prohibited from establishing margin accounts without the prior approval of the commissioner; except that the commissioner shall approve reasonable plans for domestic insurance companies to use financial futures or short selling techniques for hedging purposes.

(4) The commissioner may promulgate rules as necessary to implement this section.

Source: L. 2001: Entire section added, p. 283, § 9, effective March 30. **L. 2014:** (1)(b)(II)(A), (1)(d), (2)(a), and (2)(e) amended and (4) added, (SB 14-152), ch. 312, p. 1317, § 1, effective July 1. **L. 2015:** (4) amended, (SB 15-264), ch. 259, p. 944, § 13, effective August 5.

Editor's note: Subsection (4) was numbered as (3) in SB 14-152 but has been renumbered on revision for ease of location.

10-3-244. Climate risk disclosure - insurer participation - rules - reporting - definition. (1) The commissioner shall adopt rules requiring that, beginning in 2024, an insurer issued a certificate of authority to transact business pursuant to part 1 of this article 3 that reports more than one hundred million dollars on its annual NAIC schedule T filing, or such other threshold dollar amount that the NAIC establishes in subsequent years, must participate in and complete the NAIC's annual "Insurer Climate Risk Disclosure Survey", or such other survey or reporting mechanism that the NAIC adopts in subsequent years. If an insurer reports less than one hundred million dollars on its annual NAIC schedule T filing, or such other threshold dollar amount that the NAIC establishes in subsequent years, the insurer may participate in and complete the survey voluntarily.

(2) As used in this section, "NAIC" means the National Association of Insurance Commissioners, an organization of insurance regulators from the fifty states of the United States, the District of Columbia, and the five United States territories.

Source: L. 2023: Entire section added, (SB 23-016), ch. 165, p. 729, § 1, effective August 7.

PART 3

UNIFORM GUARANTY DEPOSITS

10-3-301. Definitions. As used in this part 3, unless the context otherwise requires:

(1) "Alien insurer" means any insurer incorporated or organized under the laws of any country other than the United States.

(2) "Domestic insurer" means any insurer incorporated or organized under the laws of this state.

(3) "Foreign insurer" means any insurer incorporated or organized under the laws of any state, as defined in this section, other than this state.

(4) "Insurer" means any insurance company except a life insurance company and includes any reciprocal or interinsurance exchange.

(5) "Policyholders" means claimants under the insurer's policies, claimants having claims which arise under or by reason of the insurer's policies, and obligees under its surety contracts.

(6) "State" means any state of the United States, the Commonwealth of Puerto Rico, and the District of Columbia.

(7) "United States" means the states of the United States, the Commonwealth of Puerto Rico, and the District of Columbia.

Source: L. 53: p. 360, § 1. **CRS 53:** § 72-16-1. **C.R.S. 1963:** § 72-15-1.

10-3-302. Deposits required - when. No foreign or alien insurer authorized to transact business in this state, except a life insurance company, shall do such business unless it deposits

and continuously maintains with the commissioner, or with an official of some other state of the United States designated by law to accept such deposit, cash, or securities having a fair market value of not less than the amounts required to be deposited for such insurers by the statutes of the state of Colorado. Such deposit shall be held for the benefit and protection of all the policyholders of such insurer in the United States. If the deposit is made with an official of some other state, the commissioner shall be furnished with and shall accept as evidence of deposit the certificate of such state officer under his hand and seal certifying that he holds such deposit for the benefit and protection of all the policyholders of such insurer in the United States. The provisions of this part 3 excepting life insurance companies from its stipulations shall not in any manner affect the duty and obligation of such companies to comply with the requirements of section 10-3-201, concerning cash capital, guaranty fund deposits, and surplus, and all such life insurance companies shall strictly comply therewith.

Source: L. 53: p. 361, § 2. **CRS 53:** § 72-16-2. **L. 57:** p. 466, § 1. **C.R.S. 1963:** § 72-15-2. **L. 69:** p. 500, § 7.

10-3-303. Deposits with commissioner. In the event any domestic insurer or alien insurer using this state as a state of entry into the United States is required, pursuant to the laws of any other state, country, province, district, or territory, to make a deposit differing in amount or character from the deposit required of domestic insurers by the laws of this state, such insurer may deposit with the commissioner cash or securities of the kind and amount sufficient to enable the insurer to meet such requirement, and the commissioner shall issue a certificate as evidence of such deposit for filing with an official of such other state, country, province, district, or territory.

Source: L. 53: p. 361, § 3. **CRS 53:** § 72-16-3. **C.R.S. 1963:** § 72-15-3.

Cross references: For the deposit and safekeeping of deposits generally, see § 10-3-210.

10-3-304. Depositaries - responsibility. Upon request of the insurer, the commissioner may designate any solvent trust company or other solvent financial institution having trust powers domiciled in this state as the commissioner's depositary to receive and hold any such deposit. Any such deposit so held shall be at the expense of the insurer. The state of Colorado shall be responsible for the safekeeping and return of all funds and securities deposited pursuant to this part 3 with the commissioner or in any such depositary so designated by him.

Source: L. 53: p. 361, § 4. **CRS 53:** § 72-16-4. **C.R.S. 1963:** § 72-15-4.

Cross references: For the deposit and safekeeping of deposits generally, see § 10-3-210.

10-3-305. Rights of depositors. (1) So long as the insurer remains solvent and complies with this part 3, it may:

(a) Demand, receive, sue for, and recover the income from securities or cash deposited in accordance with this part 3;

(b) Exchange and substitute for the deposited cash or securities, or any part thereof, cash or eligible securities of equivalent or greater value; and

(c) Inspect, at reasonable times, any deposit made in accordance with this part 3.

Source: L. 53: p. 362, § 5. **CRS 53:** § 72-16-5. **C.R.S. 1963:** § 72-15-5.

10-3-306. Release of deposits. (1) Any deposit made in this state under this part 3 shall be released and returned:

(a) To the insurer upon extinguishment by reinsurance or otherwise of all liability of the insurer for the security of which the deposit is held; or

(b) To the insurer to the extent such deposit is in excess of the amount required; or

(c) Upon proper order of a court of competent jurisdiction to the receiver, conservator, rehabilitator, liquidator of the insurer, or any other properly designated official who succeeds to the management and control of the insurer's assets.

Source: L. 53: p. 362, § 6. **CRS 53:** § 72-16-6. **C.R.S. 1963:** § 72-15-6.

10-3-307. Commissioner order release. No such release shall be made except upon application to and the written order of the commissioner. The commissioner shall have no personal liability for any such release of any such deposit or part thereof so made by him in good faith.

Source: L. 53: p. 362, § 7. **CRS 53:** § 72-16-7. **C.R.S. 1963:** § 72-15-7.

PART 4

DELINQUENCIES

10-3-401. Legislative declaration. (1) The purpose of this part 4 is to make available to the commissioner supplemental remedial authority in instances of insurance company delinquencies of various kinds and degrees which demand regulation and control by the commissioner in order to effectuate his responsibility that the business of insurance in this state is conducted according to law and his responsibility to protect the policyholders and public of this state. Most delinquencies are of such a kind or degree as to not justify the imposing of the remedy or sanction of loss of certificate or of rehabilitation or liquidation by court order. Either of the remedies of loss of certificate or of rehabilitation or liquidation by court order would in many instances defeat any realistic opportunity to rehabilitate the delinquent company. Such remedies are likely to destroy or diminish one or more of the following values or assets: The value of the insurance account or in-force business of the insurer; the value of the insurer as a going concern; the value of its agency force; and the value of other of its assets.

(2) The remedial steps provided by this part 4 are provided with the purpose in mind that insurance companies committing or suffering a delinquency be rehabilitated where and whenever possible with no loss of public confidence in the companies, and thus avoid the loss of a certificate of or the institution of rehabilitation or liquidation proceedings, by court order, against any insurance company, where possible. Furthermore, the remedial steps provided in this

part 4 are provided to protect the assets of an insurer pending determination of whether or not the insurer can be successfully rehabilitated. In instances where rehabilitation or liquidation by court order are inevitable, it is nevertheless the purpose of this part 4 to allow preliminary or emergency supervision to prevent a dissipation of assets from taking place, and thus benefit the policyholders of the company. In such an instance, this part 4 shall operate in conjunction with part 5 of this article.

Source: L. 69: p. 544, § 3. **C.R.S. 1963:** § 72-29-1. **L. 92:** Entire section amended, p. 1424, § 5, effective July 1.

10-3-402. Definitions. All terms defined in section 10-1-102 shall have the same meaning in this part 4. As used in this part 4, unless the context otherwise requires:

(1) (Deleted by amendment, L. 92, p. 1425, § 6, effective July 1, 1992.)

(2) "Delinquency" means any act, omission, or condition, or combination thereof, which is contrary to the applicable laws of this state or any other state, including any regulation lawfully promulgated by the commissioner of insurance of any state or any other person or state agency having supervision of the business of insurance. It includes, but is not limited to, any such act, omission, or condition, or combination thereof, committed or created by or under the direction or authority of any insurance company or any officer or representative thereof. Specifically, it includes any act, omission, or condition, or combination thereof, which, although not otherwise proscribed by law, nevertheless renders the operation of the insurance company hazardous to the public or its policyholders.

(3) "Direct supervision" means the institution of control of an insurance company by order of the commissioner whereby one or more specifically enumerated acts shall be required of the company by order of the commissioner, or one or more specifically enumerated acts or decisions of the company shall not be permitted without prior written approval of the commissioner. In addition, such term includes the power to take all steps necessary to preserve, protect, and recover an insurance company's assets as set forth in section 10-3-405 (2). It is a condition of control beyond normal regulation by the division of insurance and beyond the notifying of an insurance company of a determination of delinquency by the commissioner and supplying the company a list of requirements to abate the condition.

(4) "Rehabilitation" or "to rehabilitate" refers to the removal of an existing delinquency and restoration of the company to a condition of compliance with the law.

Source: L. 69: p. 545, § 3. **C.R.S. 1963:** § 72-29-3. **L. 92:** Entire section amended, p. 1425, § 6, effective July 1.

10-3-403. Scope of part 4. In addition to, and not to the exclusion of, any remedies or powers otherwise available to him, the commissioner may elect to take action against any insurance company formed or incorporated under the laws of this state or doing business in this state, whether authorized or not, which commits or suffers a delinquency according to the provisions of this part 4.

Source: L. 69: p. 545, § 3. **C.R.S. 1963:** § 72-29-2.

10-3-404. Determination of delinquency - procedure. Whenever evidence exists to the satisfaction of the commissioner that an insurance company has committed or suffered a delinquency, the commissioner may, upon determination of delinquency, notify the insurance company of his determination and furnish the insurance company a written list of requirements to abate his determination, and, if deemed necessary by the commissioner, he may place the insurance company under his direct supervision, with written notice to the company that it is so placed under direct supervision.

Source: L. 69: p. 545, § 3. **C.R.S. 1963:** § 72-29-4.

10-3-405. Direct supervision. (1) Any insurance company placed under direct supervision shall remain under direct supervision until all delinquencies are remedied, or until the commissioner deems such direct supervision no longer is necessary or desirable. During the period of direct supervision, the commissioner may appoint a supervisor other than himself to supervise the company and may provide that the company may not take any of the following actions without prior approval in writing of the commissioner or his duly appointed supervisor:

(a) Dispose of, convey, or encumber any of its assets or its business in force;

(b) Withdraw any of its bank accounts;

(c) Lend any of its funds;

(d) Invest any of its property;

(e) Transfer any of its property;

(f) Incur any debt, obligation, or liability;

(g) Merge or consolidate with another company;

(h) Enter into any new reinsurance contract or treaty.

(2) In addition to the power to require prior written approval of any of the actions set forth in subsection (1) of this section, the commissioner or the commissioner's duly appointed supervisor may take any further steps necessary to preserve, protect, and recover any assets or property of an insurance company under direct supervision.

Source: L. 69: p. 546, § 3. **C.R.S. 1963:** § 72-29-5. **L. 92:** Entire section amended, p. 1425, § 7, effective July 1.

10-3-406. Protest of finding of delinquency. In the event the insurance company protests the determination of delinquency by the commissioner, the commissioner shall stay his decision to place the insurance company under direct supervision and shall give the insurance company not less than fifteen days to show cause, at a hearing conducted by the commissioner, why such a determination should not be made. In cases of emergency, the commissioner may allow his determination of delinquency to stand until the insurance company, under the show cause order or at the hearing, gives sufficient proof that the commissioner's determination was erroneous.

Source: L. 69: p. 546, § 3. **C.R.S. 1963:** § 72-29-6.

10-3-407. Costs of direct supervision. All costs incident to the services of direct supervision shall be determined by the commissioner, and all reasonable costs so determined shall be a charge against the assets and funds of the insurance company so directly supervised.

Source: L. 69: p. 546, § 3. **C.R.S. 1963:** § 72-29-7.

10-3-408. Conservatorship. (Repealed)

Source: L. 69: p. 546, § 3. **C.R.S. 1963:** § 72-29-8. **L. 92:** Entire section repealed, p. 1426, § 8, effective July 1.

10-3-409. Protest of order of conservatorship. (Repealed)

Source: L. 69: p. 547, § 3. **C.R.S. 1963:** § 72-29-9. **L. 92:** Entire section repealed, p. 1427, § 9, effective July 1.

10-3-410. Costs of conservatorship. (Repealed)

Source: L. 69: p. 547, § 3. **C.R.S. 1963:** § 72-29-10. **L. 92:** Entire section repealed, p. 1427, § 10, effective July 1.

10-3-411. Penalties for noncompliance. Any insurance company or any officer or official thereof who willfully fails to comply with an order of the commissioner while such insurance company is under direct supervision of the commissioner commits a class 2 misdemeanor.

Source: L. 69: p. 547, § 3. **C.R.S. 1963:** § 72-29-11. **L. 92:** Entire section amended, p. 1427, § 11, effective July 1. **L. 2021:** Entire section amended, (SB 21-271), ch. 462, p. 3148, § 113, effective March 1, 2022.

Cross references: For the penalty for a class 2 misdemeanor, see § 18-1.3-501.

10-3-412. Review of action while under direct supervision. At any time during the period of direct supervision, or at any time pending abatement of the commissioner's determination of delinquency, the insurance company may request the commissioner, or his duly appointed deputy, to review an action taken or proposed to be taken by the direct supervisor, specifying in what manner the action complained of is believed not to be in the best interests of the insurance company. The insurance company shall be entitled to a hearing on such a request, if desired by the company.

Source: L. 69: p. 547, § 3. **C.R.S. 1963:** § 72-29-12. **L. 92:** Entire section amended, p. 1427, § 12, effective July 1.

10-3-413. Appeal from final determination or order of commissioner. (1) Upon exhausting all means of administrative appeal provided in this part 4, or in case the

commissioner, under section 10-3-406, refuses to stay his order or determination pending the show cause order and hearing, the insurance company aggrieved by such determination or order may avail itself of the following procedure of appeal and none other:

(a) The insurance company shall file a petition setting forth its particular objection to the order or determination in the district court in and for the city and county of Denver, and not elsewhere, against the commissioner as defendant. Said action shall have precedence over all other cases on the docket of a different nature. The action shall not be limited to questions of law but shall be tried and determined upon a trial de novo.

(b) Either party to said action may appeal to the appellate court having jurisdiction of said cause of action, and said appeal shall have precedence in the appellate court over all causes of action of a different character pending in the appellate court.

(2) The commissioner is not required to give any appeal bond in any cause arising under this section.

Source: L. 69: p. 547, § 3. **C.R.S. 1963:** § 72-29-13. **L. 92:** IP(1) amended, p. 1428, § 13, effective July 1.

10-3-414. Nondisclosure of reports and evidence during period of direct supervision or conservatorship. Any other provision of law notwithstanding, the commissioner shall not divulge to the public any examination report, results of investigation, or other information received by the division of insurance on, about, or relating to any insurance company which would be detrimental to the efforts of rehabilitation of that company under this part 4.

Source: L. 69: p. 548, § 3. **C.R.S. 1963:** § 72-29-14.

Cross references: For the publication of reports and statements, see § 10-3-109.

PART 5

INSURERS' REHABILITATION AND LIQUIDATION

Editor's note: This part 5 was numbered as article 17 of chapter 72, C.R.S. 1963. The substantive provisions of this part 5 were repealed and reenacted in 1992, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this part 5 prior to 1992, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated.

10-3-501. Legislative declaration - intents and purposes. (1) This part 5 shall not be interpreted to limit the powers granted the commissioner by other provisions of law.

(2) This part 5 shall be liberally construed to effect the purpose stated in subsection (3) of this section.

(3) The purpose of this part 5 is to protect the interests of insureds, claimants, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers, through:

(a) Early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures;

(b) Improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;

(c) Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(d) Equitable apportionment of any unavoidable loss;

(e) Lessening the problems of interstate rehabilitation and liquidation of insurers by facilitating cooperation between states in the liquidation process and by extending the scope of personal jurisdiction over debtors of insurers outside this state;

(f) Regulation of the insurance business by means of laws relating to delinquency procedures and substantive rules relating to the insurance business generally; and

(g) The provision of a comprehensive scheme for the rehabilitation and liquidation of insurance companies and those subject to this part 5 as part of the regulation of the business of insurance, the insurance industry, and insurers in this state.

(4) The general assembly finds, determines, and declares that proceedings in cases of insurer insolvency and delinquency are an integral aspect of the business of insurance and are of vital public interest and concern.

Source: L. 92: Entire part R&RE, p. 1428, § 14, effective July 1.

10-3-502. Definitions. As used in this part 5, unless the context otherwise requires:

(1) "Ancillary state" means any state other than a domiciliary state.

(2) "Creditor" means a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, fixed or contingent, or absolute.

(3) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer.

(4) "Doing business" includes any of the following acts, whether effected by mail or otherwise:

(a) Issuing or delivering contracts of insurance to persons resident in this state;

(b) Soliciting applications for such contracts or other negotiations preliminary to the execution of such contracts;

(c) Collecting premiums, membership fees, assessments, or other consideration for such contracts;

(d) Transacting matters subsequent to execution of such contracts and arising out of them; or

(e) Operating under a license or certificate of authority, as an insurer, issued by the commissioner or the insurance department of any state other than Colorado.

(5) "Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

(6) "Fair consideration" is given for property or an obligation when:

(a) In exchange for such property or obligation in good faith and as a fair equivalent therefor, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(b) Such property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.

(6.5) "Federal home loan bank" means an institution chartered under the "Federal Home Loan Bank Act", 12 U.S.C. sec. 1421 et seq., or its successor statute.

(7) "Foreign country" means any other jurisdiction not in any state.

(8) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

(9) "Guaranty association" means the Colorado insurance guaranty association created in part 5 of article 4 of this title, the life and health insurance protection association created in article 20 of this title, and any other similar entity now or hereafter created by this state for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entity now in existence in, or hereafter created by, any other state.

(10) "Insolvency" or "insolvent" means:

(a) For an insurer issuing only assessable fire insurance policies:

(I) The inability to pay any obligation within thirty days after the obligation becomes payable; or

(II) If an assessment is made within thirty days after the date the obligation becomes payable, the inability to pay such obligation thirty days following the date specified in the first assessment notice issued after the date of loss.

(b) For any other insurer, that it is unable to pay its obligations when they are due, or that it is deemed insolvent pursuant to section 10-3-212.

(11) "Insurance department" means the commissioner or other government official or agency of a state other than Colorado exercising powers and duties substantially equivalent to those of the commissioner or the division.

(12) "Insurer" means any person who has done, purports to do, is doing, or is licensed to do an insurance business and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by, the commissioner or any insurance department.

(13) "Preferred claim" means any claim with respect to which the terms of this part 5 accord priority of payment from the general assets of the insurer.

(14) "Receiver" means a receiver, liquidator, rehabilitator, or conservator.

(15) "Reciprocal state" means any state other than this state in which, in substance and effect, sections 10-3-517 (1), 10-3-551, 10-3-552, 10-3-554, 10-3-555, and 10-3-556 are in force, and in which provisions are in force requiring that the commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

(16) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

(17) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(18) "State" means any state, district, or territory of the United States and the Panama canal zone.

(19) "Transfer" includes the sale and any other or different mode, direct or indirect, of disposing of or parting with property or any interest therein, or with the possession thereof, or of fixing a lien upon property or upon any interest therein, absolutely or conditionally, voluntarily, either by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

Source: L. 92: Entire part R&RE, p. 1429, § 14, effective July 1. **L. 2014:** (6.5) added, (HB 14-1215), ch. 57, p. 257, § 1, effective March 21.

Editor's note: This section is similar to former § 10-3-502 as it existed prior to 1992.

Cross references: For insurance definitions generally, see § 10-1-102.

10-3-503. Persons covered. (1) The proceedings authorized by this part 5 may be applied to:

(a) All insurers who are doing, or have done, an insurance business in this state and against whom claims arising from that business may exist now or in the future;

(b) All insurers who purport to do an insurance business in this state;

(c) All insurers who have insureds resident in this state;

(d) All other persons organized or in the process of organizing with the intent to do an insurance business in this state;

(e) All fraternal benefit societies and beneficial societies subject to article 14 of this title;

(f) All title insurance companies subject to the "Title Insurance Code of Colorado", article 11 of this title;

(g) All health-care plans subject to parts 1, 4, and 5 of article 16 of this title 10; and

(h) All employers' self-insurance pools created pursuant to section 8-44-205, C.R.S.

Source: L. 92: Entire part R&RE, p. 1431, § 14, effective July 1. **L. 2020:** (1)(g) amended, (HB 20-1402), ch. 216, p. 1042, § 10, effective June 30.

10-3-504. Jurisdiction - venue. (1) No delinquency proceeding shall be commenced under this part 5 by anyone other than the commissioner, and no court shall have jurisdiction to entertain, hear, or determine any proceeding commenced by any other person.

(2) The district court in and for the city and county of Denver shall have jurisdiction to entertain, hear, or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer, or praying for an

injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings other than in accordance with this part 5.

(3) In addition to other grounds for jurisdiction provided by law, the district court in and for the city and county of Denver has jurisdiction over a person served pursuant to the rules of civil procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state if:

(a) The person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted in any action resulting from or incident to such a relationship with the insurer; or

(b) The person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract; or

(c) The person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer; or

(d) The person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning such assets; or

(e) The person served is obligated to the insurer in any way whatsoever, in any action on or incident to the obligation.

(4) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

(5) All actions authorized pursuant to this part 5 shall be brought in the district court in and for the city and county of Denver.

Source: L. 92: Entire part R&RE, p. 1432, § 14, effective July 1.

Editor's note: This section is similar to former § 10-3-503 as it existed prior to 1992.

10-3-504.5. Application for receivership - penalty. No application or proceeding for a receivership of any domestic insurance company shall be made in any court in this state by any person, nor shall any court receive or entertain any such application or proceeding, unless and until such application is approved by the commissioner, and then such application shall be made only by the attorney general of the state. The commissioner shall not give said approval until after the examination and hearing by the commissioner and the attorney general, which shall not be made public, at which the company affected shall be given ample opportunity to submit the facts as to its condition. Any person who violates any provisions of this section commits a class 2 misdemeanor.

Source: L. 92: Entire part R&RE, p. 1433, § 14, effective July 1. **L. 2021:** Entire section amended, (SB 21-271), ch. 462, p. 3148, § 114, effective March 1, 2022.

Editor's note: This section is similar to former § 10-3-503 as it existed prior to 1992.

Cross references: For the penalty for a class 2 misdemeanor, see § 18-1.3-501.

10-3-505. Injunctions - orders. (1) Any receiver appointed in a proceeding under this part 5 may at any time apply for, and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

(a) The transaction of further business;

(b) The transfer of property;

(c) Interference with the receiver or with a proceeding under this part 5;

(d) Waste of the insurer's assets;

(e) Dissipation or transfer, or both, of bank accounts;

(f) The institution or further prosecution of any actions or proceedings;

(g) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets, or its policyholders;

(h) The levying of execution against the insurer, its assets, or its policyholders;

(i) The making of any sale or deed for nonpayment of taxes or assessments that would tend to lessen the value of the assets of the insurer;

(j) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(k) Any other threatened or contemplated action that might tend to lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders or the administration of any proceeding under this part 5.

(2) The receiver may, if necessary, apply to any court outside of the state for the relief described in subsection (1) of this section.

(3) Notwithstanding subsections (1) and (2) of this section and any other provision of this title, a federal home loan bank shall not be stayed, enjoined, or prohibited from exercising or enforcing any right or cause of action regarding collateral pledged under a security agreement or under any pledge agreement, security agreement, collateral agreement, guarantee agreement, or other similar arrangement or credit enhancement relating to a security agreement to which the federal home loan bank is a party.

Source: L. 92: Entire part R&RE, p. 1434, § 14, effective July 1. **L. 2014:** (3) added, (HB 14-1215), ch. 57, p. 257, § 2, effective March 21.

10-3-506. Cooperation of officers, owners, and employees. (1) Any officer, manager, director, trustee, owner, employee, or agent of any insurer, or any other person with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner in any proceeding under this part 5 or any investigation preliminary to the proceeding. The term "person" as used in this section shall include any person who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to, the following:

(a) To reply promptly in writing to any inquiry from the commissioner requesting such a reply; and

(b) To make available to the commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in the person's possession, custody, or control.

(2) No person shall obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(3) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings or other orders.

(4) Any person included within subsection (1) of this section who fails to cooperate with the commissioner, or any person who obstructs or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any valid order of the commissioner issued pursuant to this part 5 may:

(a) Be subject to a fine not to exceed ten thousand dollars or to imprisonment for a term of not more than one year, or both; or

(b) After a hearing, be subject to the imposition by the commissioner of a civil penalty not to exceed ten thousand dollars or to the revocation or suspension of any insurance licenses issued by the commissioner, or to both such civil penalty and such revocation or suspension.

Source: L. 92: Entire part R&RE, p. 1434, § 14, effective July 1.

10-3-507. Continuation of delinquency proceedings. Every proceeding commenced prior to July 1, 1992, shall be deemed to have been commenced under this part 5 for the purpose of conducting the proceeding thereafter; except that, in the discretion of the commissioner, the proceeding may be continued, in whole or in part, as it would have been continued had this part 5 not been enacted.

Source: L. 92: Entire part R&RE, p. 1435, § 14, effective July 1.

10-3-508. Condition on release from delinquency proceedings. (1) No insurer subject to any delinquency proceedings, whether formal, informal, administrative, or judicial, shall:

(a) Be released from such proceeding, unless such proceeding is converted into a judicial rehabilitation or liquidation proceeding;

(b) Be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

(c) Be returned to the control of its shareholders or private management; or

(d) Have any of its assets returned to the control of its shareholders or private management until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

Source: L. 92: Entire part R&RE, p. 1435, § 14, effective July 1.

10-3-509. Court's seizure order. (1) The commissioner may file in the district court in and for the city and county of Denver a petition alleging, with respect to a domestic insurer:

(a) That there exists any fact or circumstance that would justify a court order for a formal delinquency proceeding against an insurer under this part 5;

(b) That the interests of policyholders, creditors, or the public will be endangered by delay; and

(c) That an order, the contents of which shall be furnished to the court by the commissioner, is necessary to protect the interests of policyholders, creditors, or the public.

(2) Upon a filing pursuant to subsection (1) of this section, the court may issue forthwith, ex parte, and without a hearing, the requested order which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by the insurer for transaction of its business, and shall until further order of the court enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner.

(3) The court shall specify in the order what its duration shall be, which shall be such time as the court deems necessary for the commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this part 5 after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this part 5 shall ipso facto vacate the seizure order. For purposes of this section, a "formal proceeding" means any liquidation or rehabilitation proceeding.

(4) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(5) An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of such order for a hearing and review of the order. The court shall hold such a hearing and review not more than fifteen days after the request. A hearing under this subsection (5) may be held privately in chambers and it shall be so held if the insurer proceeded against so requests. The court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the order and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(6) If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given to such person. An order that notice be given shall not stay the effect of any order previously issued by the court.

Source: L. 92: Entire part R&RE, p. 1436, § 14, effective July 1.

10-3-510. Confidentiality of hearings. In all proceedings and judicial reviews thereof under section 10-3-509, all records of the insurer, other documents, and all division files and court records and papers, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the court, after hearing arguments from the parties in chambers, shall order otherwise or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the clerk of the court shall be held in a confidential file.

Source: L. 92: Entire part R&RE, p. 1437, § 14, effective July 1.

10-3-511. Grounds for rehabilitation. (1) The commissioner may apply by petition to the district court in and for the city and county of Denver for an order authorizing the commissioner to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

(a) The insurer is in such condition that the further transaction of business would be hazardous financially to its policyholders or creditors or to the public.

(b) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(c) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether such person is an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

(d) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy.

(e) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the commissioner concerning the insurer's affairs, whether in this state or elsewhere, and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate the employment and status of the person and all of such person's influence on management.

(f) After demand by the commissioner under section 10-1-204 or under this part 5, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer insofar as they pertain to the insurer.

(g) Without first obtaining the written consent of the commissioner, the insurer has transferred, or attempted to transfer, in a manner contrary to part 7 or 8 of this article, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(h) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, sequestrator, or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and such appointment has been made or is imminent, and such appointment might oust the courts of this state of jurisdiction or might prejudice the orderly conduct of delinquency proceedings pursuant to this part 5.

(i) The insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the commissioner.

(j) The insurer has failed to pay within thirty days after the due date any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which such judgment was entered had jurisdiction over such subject matter; except that such

nonpayment shall not be a ground for rehabilitation until thirty days after the termination of any good-faith effort by the insurer to contest the obligation, whether such effort is made before the commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(k) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the commissioner, has failed to give an adequate explanation for such failure immediately.

(l) The board of directors of, or the holders of a majority of the shares entitled to vote in, or a majority of those individuals entitled to the control of, those entities specified in section 10-3-503 request or consent to rehabilitation under this part 5.

(m) The insurer is impaired as defined in section 10-3-212.

Source: L. 92: Entire part R&RE, p. 1438, § 14, effective July 1.

10-3-512. Rehabilitation orders. (1) An order to rehabilitate the business of a domestic insurer or an alien insurer domiciled in this state shall appoint the commissioner as the rehabilitator and shall direct the rehabilitator forthwith to take possession of the assets of the insurer and to administer such assets under the general supervision of the court. The filing or recording of the order with the clerk of the district court in and for the city and county of Denver or with the recorder of deeds of the county in which the principal business of the company is conducted or the county in which its principal office or place of business is located shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded with such recorder of deeds. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(2) Any order issued under this section shall require accounting to the court by the rehabilitator. Accounting shall be at such intervals as the court specifies in its order, but no less frequently than semiannually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan under section 10-3-513 (4) will be prepared by the rehabilitator and the timetable for doing so.

(3) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contract of the insurer, nor shall it be a basis for retroactive revocation or retroactive cancellation of any contract of the insurer, unless such revocation or cancellation is done by the rehabilitator pursuant to section 10-3-513.

Source: L. 92: Entire part R&RE, p. 1439, § 14, effective July 1.

10-3-513. Powers and duties of rehabilitator. (1) The commissioner as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the commissioner may employ such counsel, clerks, and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the commissioner, subject to the approval of the court, and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the commissioner. The commissioner, as rehabilitator, may, with the approval

of the court, appoint an advisory committee of policyholders, claimants, or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve at the pleasure of the commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the commissioner or by the court in rehabilitation proceedings conducted under this part 5.

(2) The rehabilitator may take such action as the rehabilitator deems necessary or appropriate to reform and revitalize the insurer, and shall have all the powers of the insurer's directors, officers, and managers, whose authority shall be suspended except insofar as they are redelegated by the rehabilitator. The rehabilitator shall have full power to direct, manage, hire, and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(3) If it appears to the rehabilitator that there has been criminal or tortious conduct or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, or other person, the rehabilitator may pursue all appropriate legal remedies on behalf of the insurer.

(4) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, if all rights of shareholders are first relinquished, the plan proposed may include the imposition of liens upon the policies of the company. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(5) The rehabilitator shall have the power under sections 10-3-525 and 10-3-526 to avoid fraudulent transfers.

Source: L. 92: Entire part R&RE, p. 1440, § 14, effective July 1.

10-3-514. Actions by and against rehabilitator. (1) Any court in this state before which any action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for a minimum of ninety days and for such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as the rehabilitator deems necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(2) No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action against the insurer that might

have been commenced when the petition was filed may be commenced within a period of not less than sixty days after the order of rehabilitation is entered or the petition is denied. The rehabilitator may, upon an order for rehabilitation, within one year or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon any cause of action against which the period of limitation fixed by applicable law had not expired at the time of the filing of the petition upon which such order is entered.

(3) Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

(4) Notwithstanding subsection (1) of this section and any other provision of this title, a federal home loan bank shall not be stayed, enjoined, or prohibited from exercising or enforcing any right or cause of action regarding collateral pledged under a security agreement or under any pledge agreement, security agreement, collateral agreement, guarantee agreement, or other similar arrangement or credit enhancement relating to a security agreement to which the federal home loan bank is a party.

Source: L. 92: Entire part R&RE, p. 1441, § 14, effective July 1. **L. 2014:** (4) added, (HB 14-1215), ch. 57, p. 257, § 3, effective March 21.

10-3-514.5. Immunity and indemnification of receiver and employees - applicability. (1) For the purposes of this section, the persons entitled to protection are:

(a) All receivers responsible for the conduct of a delinquency proceeding under this part 5 including present and former receivers; and

(b) Their employees, meaning all present and former special deputies and assistant special deputies appointed by the commissioner and all persons whom the commissioner, special deputies, or assistant special deputies have employed to assist in a delinquency proceeding under this part 5. Attorneys, accountants, auditors, and other professional persons or firms who are retained by the receiver as independent contractors and their employees shall not be considered employees of the receiver for purposes of this section.

(2) The receiver and his employees shall have official immunity and shall be immune from suit and liability, both personally and in their official capacities, for any claim for damage to or loss of property or personal injury or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or any employee arising out of or by reason of their duties or employment; except that nothing in this subsection (2) shall be construed to hold the receiver or any employee immune from suit and liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the receiver or of any employee.

(3) If any legal action is commenced against the receiver or any employee, whether against him personally or in his official capacity, alleging property damage, property loss, personal injury, or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or any employee arising out of or by reason of their duties or employment, the receiver and any employee shall be indemnified from the assets of the insurer for all expenses, attorney fees, judgments, settlements, decrees, or amounts due and owing or paid in satisfaction of or incurred in the defense of such legal action unless it is determined upon a final adjudication on the merits that the alleged act, error, or omission of the receiver or

employee giving rise to the claim did not arise out of or by reason of his duties or employment, or was caused by intentional or willful and wanton misconduct.

(4) Attorney fees and any and all related expenses incurred in defending a legal action for which immunity or indemnity is available under this section shall be paid from the assets of the insurer, as they are incurred, in advance of the final disposition of such action upon receipt of an undertaking by or on behalf of the receiver or employee to repay the attorney fees and expenses if it shall ultimately be determined upon a final adjudication on the merits that the receiver or employee is not entitled to immunity or indemnity under this section.

(5) Any indemnification for expense payments, judgments, settlements, decrees, attorney fees, surety bond premiums, or other amounts paid from the insurer's assets pursuant to this section shall be an administrative expense of the insurer.

(6) In the event of any actual or threatened litigation against a receiver or any employee for which immunity or indemnity may be available under this section, a reasonable amount of funds which in the judgment of the commissioner may be needed to provide immunity or indemnity shall be segregated and reserved from the assets of the insurer as security for the payment of indemnity until such time as all applicable statutes of limitation have run and all actual or threatened actions against the receiver or any employee have been completely and finally resolved and all obligations of the insurer and the commissioner under this section have been satisfied.

(7) In lieu of segregation and reservation of funds, the commissioner may, in the commissioner's discretion, obtain a surety bond or make other arrangements which will enable the commissioner to fully secure the payment of all obligations under this section.

(8) If any legal action against an employee for which indemnity may be available under this section is settled prior to final adjudication on the merits, the insurer shall pay the settlement amount on behalf of the employee, or indemnify the employee for the settlement amount, unless the commissioner determines:

(a) That the claim did not arise out of or by reason of the employee's duties or employment; or

(b) That the claim was caused by the intentional or willful and wanton misconduct of the employee.

(9) In any legal action in which the receiver is a defendant, that portion of any settlement relating to the alleged act, error, or omission of the receiver shall be subject to the approval of the court before which the delinquency proceeding is pending. The court shall not approve that portion of the settlement if it determines:

(a) That the claim did not arise out of or by reason of the receiver's duties or employment; or

(b) That the claim was caused by the intentional or willful and wanton misconduct of the receiver.

(10) Nothing contained or implied in this section shall operate, or be construed or applied, to deprive the receiver or any employee of any immunity, indemnity, benefits of law, rights, or any defense otherwise available.

(11) (a) Subsection (2) of this section shall apply to any suit based in whole or in part on any alleged act, error, or omission occurring on or after July 1, 1992.

(b) No legal action shall lie against the receiver or any employee based in whole or in part on any alleged act, error, or omission which took place prior to July 1, 1992, unless suit is filed and valid service of process is obtained within twelve months after July 1, 1992.

(c) Subsections (3) to (9) of this section shall apply to any suit which is pending on or filed after July 1, 1992, without regard to when the alleged act, error, or omission took place.

Source: L. 92: Entire part R&RE, p. 1442, § 14, effective July 1.

10-3-515. Termination of rehabilitation. (1) Whenever the commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile, the commissioner may petition the district court in and for the city and county of Denver for an order of liquidation. A petition under this subsection (1) shall have the same effect as a petition under section 10-3-516. The court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(2) The protection of the interests of insureds, claimants, and the public requires the timely performance of all insurance policy obligations. If the payment of an insurer's policy obligations is suspended in substantial part for a period of six months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under section 10-3-513 (5), the rehabilitator shall petition the court for an order of liquidation on grounds of insolvency.

(3) The rehabilitator may at any time petition the district court in and for the city and county of Denver for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 10-3-511 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The court may also make such a finding and issue such an order at any time upon its own motion.

Source: L. 92: Entire part R&RE, p. 1445, § 14, effective July 1.

10-3-516. Grounds for liquidation. (1) The commissioner may petition the district court in and for the city and county of Denver for an order directing the commissioner to liquidate a domestic insurer or an alien insurer domiciled in this state on the basis:

(a) Of any ground for an order of rehabilitation as specified in section 10-3-511, whether or not there has been a prior order directing the rehabilitation of the insurer;

(b) That the insurer is insolvent; or

(c) That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

Source: L. 92: Entire part R&RE, p. 1446, § 14, effective July 1.

10-3-517. Liquidation orders. (1) An order to liquidate the business of a domestic insurer shall appoint the commissioner as liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with title to all of the property, contracts, rights of action, and books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the district court in and for the city and county of Denver and the recorder of deeds of the county in which its principal office or place of business is located or, in the case of real estate, with the recorder of deeds of the county where the property is located, shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds.

(2) Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation except as provided in sections 10-3-518 and 10-3-536.

(3) An order to liquidate the business of an alien insurer domiciled in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer; except that the assets and the business in the United States shall be the only assets and business included therein.

(4) At the time of petitioning for an order of liquidation or at any time thereafter, the commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and holding such hearing as it deems proper, the court may make the declaration.

(5) Any order issued under this section shall require financial reports to the court by the liquidator. Financial reports shall include, at a minimum, the assets and liabilities of the insurer and all funds received or disbursed by the liquidator during the current period. Financial reports shall be filed within one year of the liquidation order and at least annually thereafter.

(6) Within five days after July 1, 1992, or, if later, within five days after the initiation of an appeal of an order of liquidation, unless such order has been stayed, the commissioner shall present for the court's approval a plan for the continued performance of the defendant company's policy claims obligations, including the duty to defend insureds under liability insurance policies, during the pendency of the appeal. Such plan shall provide for the continued performance and payment of policy claims obligations in the normal course of events, notwithstanding the grounds alleged in support of the order of liquidation including the ground of insolvency. In the event the defendant company's financial condition will not, in the judgment of the commissioner, support the full performance of all policy claims obligations during the pendency of the appeal, the plan may prefer the claims of certain policyholders and claimants over creditors and interested parties as well as other policyholders and claimants, as the commissioner finds to be fair and equitable considering the relative circumstances of such policyholders and claimants. The court shall examine the plan submitted by the commissioner and, if it finds the plan to be in the best interests of the parties, the court shall approve the plan. No action shall lie against the commissioner or any of the commissioner's deputies, agents, clerks, assistants, or attorneys by any party based on preference in an appeal pendency plan approved by the court.

(7) The appeal pendency plan effected pursuant to subsection (6) of this section shall not supersede or affect the obligations of any insurance guaranty association.

(8) Any appeal pendency plan effected pursuant to subsection (6) of this section shall provide for equitable adjustments to be made by the liquidator to any distributions of assets to guaranty associations, in the event that the liquidator pays claims from assets of the estate which would otherwise be the obligations of any particular guaranty association but for the appeal of the order of liquidation, such that all guaranty associations equally benefit on a pro rata basis from the assets of the estate. Further, in the event an order of liquidation is set aside upon any appeal, the company shall not be released from delinquency proceedings unless and until all funds advanced by any guaranty association, including reasonable administrative expenses in connection therewith, relating to obligations of the company have been repaid in full together with interest at the judgment rate of interest, or unless an arrangement for repayment thereof has been made with the consent of all applicable guaranty associations.

Source: L. 92: Entire part R&RE, p. 1446, § 14, effective July 1.

10-3-518. Continuation of coverage. (1) All policies, including bonds and other noncancellable business but not including life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(a) A period of thirty days from the date of entry of the liquidation order;

(b) The expiration of the policy coverage;

(c) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(d) The effective date of a transfer of the policy obligation by the liquidator pursuant to section 10-3-520 (1)(i); or

(e) The date proposed by the liquidator and approved by the court to cancel coverage.

(2) An order of liquidation under section 10-3-517 shall terminate coverages at the time specified in subsection (1) of this section for purposes of any other statute.

(3) Policies of life or health insurance or annuities shall continue in force for such period and under such terms as is provided for by any applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2) of this section.

Source: L. 92: Entire part R&RE, p. 1448, § 14, effective July 1.

10-3-519. Dissolution of insurer. The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time the commissioner applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

Source: L. 92: Entire part R&RE, p. 1449, § 14, effective July 1.

10-3-520. Powers of liquidator. (1) The liquidator shall have the power:

(a) To appoint a special deputy or deputies to act for the liquidator under this part 5, and to determine the reasonable compensation of such special deputy. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator.

(b) To employ employees, agents, legal counsel, actuaries, accountants, appraisers, consultants, and such other personnel as the liquidator may deem necessary to assist in the liquidation;

(c) To appoint, subject to the approval of the court, an advisory committee of policyholders, claimants, or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve at the pleasure of the commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the commissioner or by the court in liquidation proceedings conducted under this part 5.

(d) To fix the reasonable compensation of employees, agents, legal counsel, actuaries, accountants, appraisers, and consultants subject to the approval of the court;

(e) To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the division of insurance. Any amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the division out of the first available moneys of the insurer.

(f) To hold hearings, subpoena witnesses and compel their attendance, administer oaths, examine any person under oath, and compel any person to subscribe to the person's testimony after it has been correctly reduced to writing; and, in connection therewith, to require the production of any books, papers, records, or other documents which the liquidator deems relevant to the inquiry;

(g) To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer;

(h) To collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose:

(I) To institute timely action in other jurisdictions, in order to forestall garnishment or attachment proceedings against such debts;

(II) To do such other acts as are necessary or expedient to collect, conserve, or protect its assets or property, including the power to sell, compound, compromise, or assign debts for purposes of collection upon such terms and conditions as the liquidator deems best; and

(III) To pursue any creditors' remedies available to enforce the liquidator's claims;

(i) To conduct public and private sales of the property of the insurer;

(j) To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 10-3-541;

(k) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. The liquidator shall also have power to execute, acknowledge, and deliver any and all deeds, assignments, releases, and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation.

(l) To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to such transaction for the purpose of facilitating the liquidation. Any funds so borrowed may be repaid as an administrative expense and may be given priority over any other claims in class 1 under the priority of distribution pursuant to section 10-3-541.

(m) To enter into such contracts as are necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party; except that the liquidator shall not disavow, reject, or repudiate a federal home loan bank security agreement or any pledge agreement, security agreement, collateral agreement, guarantee agreement, or other similar arrangement or credit enhancement relating to a security agreement to which a federal home loan bank is a party;

(n) To continue to prosecute and to institute in the name of the insurer or in the liquidator's own name any and all suits and other legal proceedings, in this state or elsewhere, and to abandon the prosecution of claims deemed unprofitable to pursue further. If the insurer is dissolved under section 10-3-519, the liquidator shall have the power to apply to any court in this state or elsewhere for leave to be substituted for the insurer as plaintiff.

(o) To prosecute any action which may exist on behalf of the creditors, members, policyholders, or shareholders of the insurer against any officer of the insurer or any other person;

(p) To remove any records and property of the insurer to the offices of the commissioner or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations.

(q) To deposit in one or more banks in this state such sums as are required to meet current administration expenses and dividend distributions;

(r) To invest all sums not currently needed, unless the court orders otherwise;

(s) To file any necessary documents for record in the office of any recorder of deeds or record office where property of the insurer is located, in this state or elsewhere;

(t) To assert all defenses available to the insurer as against third persons, which defenses shall include but not be limited to statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such obligation and may defend only in the absence of a defense by such guaranty associations.

(u) To exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be conferred by law whether or not such power is conferred by sections 10-3-525 to 10-3-527;

(v) To intervene in any proceeding, wherever instituted, which could result in the appointment of a receiver or trustee, and to act as the receiver or trustee whenever such appointment is offered;

(w) To enter into agreements with any receiver, commissioner, or insurance department of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states;

(x) To exercise, in a manner consistent with the provisions of this part 5, all powers now held or hereafter conferred upon receivers by the laws of this state.

(2) (a) If a company placed in liquidation issued liability policies on a claims-made basis, and if such policies provided an option to purchase an extended period to report claims, then the liquidator may make available to holders of such policies, for a charge, an extended period to report claims subject to the conditions stated in this subsection (2). The extended reporting period shall be made available only to those insureds who have not secured substitute coverage. The extended period made available by the liquidator shall begin upon termination of any extended period to report claims in the basic policy and shall end at the earlier of the final date for filing of claims in the liquidation proceeding or eighteen months after the order of liquidation.

(b) The extended period to report claims made available by the liquidator shall be subject to the terms of the policy to which it relates. The liquidator shall make available such extended period within sixty days after the order of liquidation at a charge to be determined by the liquidator subject to approval of the court. Such offer shall be deemed rejected unless the offer is accepted in writing and the charge is paid within ninety days after the order of liquidation. No commissions, premium taxes, assessments, or other fees shall be due on the charge pertaining to the extended period to report claims.

(3) The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon the liquidator, nor shall it exclude in any manner the liquidator's right to do such other acts not specifically enumerated or otherwise provided for in this section as may be necessary or appropriate for the accomplishment of, or in aid of the purpose of, liquidation.

(4) Notwithstanding the powers of the liquidator as stated in subsections (1) and (2) of this section, the liquidator shall have no obligation to defend claims or to continue to defend claims subsequent to the entry of a liquidation order.

Source: L. 92: Entire part R&RE, p. 1449, § 14, effective July 1. **L. 2014:** (1)(m) amended, (HB 14-1215), ch. 57, p. 258, § 4, effective March 21.

10-3-521. Notice to creditors and others. (1) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(a) By first-class mail and either by telegram or telephone to the insurance department of each jurisdiction in which the insurer is doing business;

(b) By first-class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

(c) By first-class mail to all insurance agents of the insurer;

(d) By first-class mail to all persons known or reasonably expected to have claims against the insurer, including all policyholders at their last-known address as indicated by the records of the insurer; and

(e) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

(2) Notice to potential claimants under subsection (1) of this section shall require claimants to file with the liquidator their claims together with proper proofs thereof under section 10-3-535, on or before a date the liquidator shall specify in the notice. Although an earlier date may be set by the liquidator, the last day to file claims shall be no later than eighteen months after the order of liquidation. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(3) Notice under subsection (1) of this section to agents of the insurer and to potential claimants who are policyholders shall include, where applicable, notice that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws.

(4) The liquidator shall promptly provide to the guaranty associations such information concerning the identities and addresses of such policyholders and their policy coverages as may be within the liquidator's possession or control and shall otherwise cooperate with guaranty associations to assist them in providing to such policyholders timely notice of the guaranty associations' coverage of policy benefits, including, as applicable, coverage of claims and continuation or termination of coverages.

(5) If notice is given in accordance with this section, the distribution of assets of the insurer under this part 5 shall be conclusive with respect to all claimants regardless of whether or not they received notice.

Source: L. 92: Entire part R&RE, p. 1453, § 14, effective July 1.

10-3-522. Duties of agents. (1) Every person who receives notice in the form prescribed in section 10-3-521 that an insurer which the person represents as an agent is the subject of a liquidation order shall, within thirty days of such notice, provide to the liquidator, in addition to the information such person may be required to provide pursuant to section 10-3-506, all information in the agent's records related to any policy issued by the insurer through the agent, and, if the agent is a general agent, the information in the general agent's records related to any policy issued by the insurer through an agent under contract to the general agent, including the name and address of such subagent. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy, or if the agent has had in the agent's possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

(2) Any agent failing to provide information to the liquidator as required in subsection (1) of this section may be subject to a penalty of not more than one thousand dollars and, in addition, any licenses of any such agent may be suspended. Such penalty or suspension, or both, shall be imposed only after a hearing held by the commissioner.

Source: L. 92: Entire part R&RE, p. 1454, § 14, effective July 1.

10-3-523. Actions by and against liquidator. (1) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, no action at law or equity or in arbitration shall be brought against the insurer or liquidator, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when such injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, the liquidator may intervene in the action. The liquidator may defend any action in which the liquidator intervenes under this section at the expense of the estate of the insurer.

(2) The liquidator may, upon or after an order for liquidation, within two years or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take any such action or do any such act required of or permitted to the insurer, if the liquidator does so within a period of one hundred eighty days subsequent to the entry of an order for liquidation or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(3) No statute of limitation or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against the insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the petition is denied.

(4) Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation.

Source: L. 92: Entire part R&RE, p. 1455, § 14, effective July 1.

10-3-524. Collection and listing of assets. (1) As soon as practicable after the liquidation order but not later than one hundred twenty days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One copy shall be filed in the office of the clerk of the district court in and for the city and county of Denver and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(2) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(3) A submission to the court for disbursement of assets in accordance with section 10-3-533 fulfills the requirements of subsection (1) of this section.

Source: L. 92: Entire part R&RE, p. 1456, § 14, effective July 1.

10-3-525. Fraudulent transfers prior to petition. (1) Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this part 5 is fraudulent as to then existing and future creditors if made or incurred without fair consideration or if made with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this part 5, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value; except that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien, or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

(2) (a) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under section 10-3-527 (3).

(b) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(d) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection (2) shall apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(3) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection (1) of this section if:

(a) The transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release; and

(b) Any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced.

(4) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (1) of this section shall be personally liable therefore and shall be bound to account to the liquidator.

(5) Notwithstanding subsection (1) of this section and any other provision of this title, a receiver shall not avoid any transfer of, or any obligation to transfer, money or any other

property arising under or in connection with a federal home loan bank security agreement or any pledge agreement, security agreement, collateral agreement, guarantee agreement, or other similar arrangement or credit enhancement relating to a security agreement to which a federal home loan bank is a party; except that a transfer may be avoided under this section if it was made with actual intent to hinder, delay, or defraud either existing or future creditors.

Source: L. 92: Entire part R&RE, p. 1456, § 14, effective July 1. **L. 2014:** (5) added, (HB 14-1215), ch. 57, p. 258, § 5, effective March 21.

10-3-526. Fraudulent transfer after petition. (1) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefore, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of deeds in the county where any real property in question is located. The exercise by a court of the United states or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(2) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(a) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefore, for which amount the transferee shall have a lien on the property so transferred.

(b) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon the insurer's order, with the same effect as if the petition were not pending.

(c) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

(d) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(3) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (1) of this section shall be personally liable therefore and shall be bound to account to the liquidator.

(4) Nothing in this part 5 shall impair the negotiability of currency or negotiable instruments.

(5) Notwithstanding subsection (1) of this section and any other provision of this title, a receiver shall not avoid any transfer of, or any obligation to transfer, money or any other

property arising under or in connection with a federal home loan bank security agreement or any pledge agreement, security agreement, collateral agreement, guarantee agreement, or other similar arrangement or credit enhancement relating to a security agreement to which a federal home loan bank is a party; except that a transfer may be avoided under this section if it was made with actual intent to hinder, delay, or defraud either existing or future creditors.

Source: L. 92: Entire part R&RE, p. 1458, § 14, effective July 1. **L. 2014:** (5) added, (HB 14-1215), ch. 57, p. 258, § 6, effective March 21.

10-3-527. Voidable preferences and liens. (1) (a) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this part 5, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(b) Any preference may be avoided by the liquidator if:

(I) The insurer was insolvent at the time of the transfer; or

(II) The transfer was made within four months before the filing of the petition; or

(III) The creditor receiving it or to be benefited thereby or the agent of any such creditor acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(IV) The creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not such person held such position, or any shareholder holding directly or indirectly more than five percent of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(c) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property; except where a bona fide purchaser or lienor has given less than fair equivalent value, such purchaser or lienor shall have a lien upon the property to the extent of the consideration actually given by the purchaser. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(d) Notwithstanding paragraph (b) of this subsection (1) and any other provision of this title, a liquidator or receiver shall not avoid any preference arising under or in connection with a federal home loan bank security agreement or any pledge agreement, security agreement, collateral agreement, guarantee agreement, or other similar arrangement or credit enhancement relating to a security agreement to which a federal home loan bank is a party.

(2) (a) (I) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(II) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(b) (I) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(II) A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(c) The provisions of this subsection (2) shall apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(3) (a) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

(b) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (2) of this section, if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (2) of this section through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

(4) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (2) of this section to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(5) If any lien deemed voidable under paragraph (b) of subsection (1) of this section has been dissolved by the furnishing of a bond or other obligation and the surety which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this part 5 which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(6) The property affected by any lien deemed voidable under subsections (1) and (5) of this section shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator; except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

(7) The district court in and for the city and county of Denver shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

(8) The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or where the property is retained under subsection (7) of this section to the extent of the amount paid to the liquidator.

(9) If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from such insurer.

(10) If an insurer shall, directly or indirectly, within four months before the filing of a successful petition for liquidation under this part 5, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney-at-law for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefits of the estate; except that, where the attorney is in a position of influence in the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by the provision of subparagraph (IV) of paragraph (b) of subsection (1) of this section.

(11) (a) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when any such person has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is a reasonable cause to so believe if the transfer was made within four months before the date of filing of a successful petition for liquidation.

(b) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (1) of this section shall be personally liable therefor and shall be bound to account to the liquidator.

(c) Nothing in this subsection (11) shall prejudice any other claim by the liquidator against any person.

Source: L. 92: Entire part R&RE, p. 1459, § 74, effective July 1. **L. 2014:** (1)(d) added, (HB 14-1215), ch. 57, p. 258, § 7, effective March 21.

10-3-528. Claims of holders of void or voidable rights. (1) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under this part 5 shall be allowed unless such creditor surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty days from the date of the entering of the final judgment; except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(2) A claim allowable under subsection (1) of this section by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused last filing under section 10-3-534 if filed within thirty days from the date of the avoidance, or within the further time allowed by the court pursuant to subsection (1) of this section.

Source: L. 92: Entire part R&RE, p. 1463, § 14, effective July 1.

10-3-529. Setoffs - effective date - applicability. (1) Notwithstanding any other provision of this title, mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this part 5, shall be set off, and the balance only shall be allowed or paid, except as provided in subsections (2) and (4) of this section and section 10-3-532.

(2) No setoff shall be allowed in favor of any person where:

(a) The obligation of the insurer to the person would not at the date of the filing of a petition for receivership entitle the person to share as a claimant in the assets of the insurer; or

(b) The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or

(c) The obligation of the insurer is owed to an affiliate of such person, or any other entity or association other than the person; or

(d) The obligation of the person is owed to an affiliate of the insurer or to any other entity or association other than the insurer; or

(e) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution; or

(f) The obligations between the person and the insurer arise from business in which either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations; except that, with regard to such business, the commissioner has discretion to allow certain setoffs if the commissioner deems them appropriate.

(3) (Deleted by amendment, L. 2001, p. 229, § 1, effective July 1, 2001.)

(4) The commissioner may promulgate rules and regulations to implement this section including the establishment of reasonable accounting requirements.

(5) Notwithstanding any other provision of this section to the contrary, a setoff of sums due on obligations in the nature of those set forth in paragraph (f) of subsection (2) of this section shall be allowed for those sums accruing from business written where the contracts were entered into, renewed, or extended with the express written approval of the insurance department

of the state of domicile of the now insolvent insurer and, in the judgment of such insurance department, it was necessary to provide reinsurance in order to prevent or mitigate a threatened impairment or insolvency of a domiciliary insurer in connection with the exercise of the said insurance department's regulatory responsibilities.

(6) This section shall be effective January 1, 1993, and shall apply to all contracts entered into, renewed, extended, or amended on or after said date and to debts or credits arising from any business written or transactions occurring after January 1, 1993, pursuant to any contract including those in existence prior to January 1, 1993, and shall supersede any agreements or contractual provisions which might be construed to enlarge the setoff rights of any person under any contract with the insurer. For purposes of this section, any change in the terms of, or consideration for, any such contract shall be deemed an amendment.

Source: L. 92: Entire part R&RE, p. 1463, § 14, effective July 1. **L. 2001:** (1), (2)(a), (2)(f), and (3) amended, p. 229, § 1, effective July 1.

10-3-530. Assessments. (1) As soon as practicable but not more than two years after the date of an order of liquidation under section 10-3-517 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

(a) The reasonable value of the assets of the insurer;

(b) The insurer's probable total liabilities;

(c) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(d) A recommendation as to whether or not an assessment should be made and in what amount.

(2) (a) Upon the basis of the report provided pursuant to subsection (1) of this section and including any supplements and amendments thereto, the district court in and for the city and county of Denver may levy one or more assessments against all members of the insurer who are subject to assessment.

(b) Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount by which the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(3) After levy of assessment under subsection (2) of this section, the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order to show cause why the liquidator should not pursue a judgment therefor.

(4) The liquidator shall give notice of the order to show cause by publication and by first-class mail to each member liable under such order mailed to the member's last-known address as it appears on the insurer's records, at least twenty days before the return day of the order to show cause.

(5) (a) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection (3) of this section, the court shall make an order adjudging the member liable for the amount of the assessment together with costs, and the liquidator shall have a judgment against the member therefor.

(b) If, on or before such return day, the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the commissioner determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(6) The liquidator may enforce any order or collect any judgment under subsection (5) of this section by any lawful means.

Source: L. 92: Entire part R&RE, p. 1465, § 14, effective July 1.

10-3-531. Reinsurers' liability. (1) Except as otherwise provided in subsection (2) of this section, the amount recoverable by the liquidator from reinsurers shall be payable under a contract or contracts reinsured by the reinsurer on the basis of reported claims allowed by the liquidation court without diminution as a result of the insolvency of the ceding insurer. Such payment shall be made directly to the ceding insurer or to its domiciliary liquidator unless the contract or other written agreement specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer.

(2) Notwithstanding subsection (1) of this section, if a life and health insurance guaranty association has elected to succeed to the rights and obligations of the insolvent insurer under the contract of reinsurance, whether pursuant to section 10-20-108 (13)(h) or otherwise, then the reinsurer's liability to pay covered reinsured claims shall continue under the contract of reinsurance, subject to the payment to the reinsurer of the reinsurance premiums for such coverage. Payment for such reinsured claims shall only be made by the reinsurer pursuant to the direction of the guaranty association or its designated successor. Any payment made at the direction of the guaranty association or its designated successor by the reinsurer shall discharge the reinsurer of all further liability to any other party for such claim payment.

Source: L. 92: Entire part R&RE, p. 1466, § 14, effective July 1. **L. 2001:** Entire section amended, p. 230, § 2, effective July 1.

10-3-532. Recovery of premiums owed. (1) (a) An agent, broker, premium finance company, or any other person other than the insured that is responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned premium that represents commission of such person. Credits or setoffs or both shall not be allowed to an agent, broker, or premium finance company for any amounts advanced to the insurer by the agent, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured.

(b) An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

(2) Upon satisfactory evidence of a violation of this section, the commissioner may pursue either one or both of the following courses of action:

(a) Suspend, revoke, or refuse to renew the licenses of such offending party or parties;

(b) Impose a penalty of not more than one thousand dollars for each and every act in violation of this section by said party or parties.

(3) Before the commissioner takes any action set forth in subsection (2) of this section, the commissioner shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation and fixing a time and place, at least ten days thereafter, when a hearing on the matter shall be held. After such hearing, or upon failure of the accused to appear at such hearing the commissioner, if the commissioner finds the accused committed any such violation, shall impose such penalties under subsection (2) of this section as are deemed advisable.

(4) When the commissioner takes action in any or all of the ways set out in subsection (2) of this section, the party aggrieved may appeal from said action to the district court in and for the city and county of Denver.

Source: L. 92: Entire part R&RE, p. 1466, § 14, effective July 1.

10-3-533. Domiciliary liquidator's proposal to distribute assets. (1) Within one hundred twenty days after a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshaled assets, from time to time and as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for such determination.

(2) The proposal referenced in subsection (1) of this section shall at least include provisions for:

(a) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in section 10-3-541 (1) and (2);

(b) Disbursement of the assets marshaled to date and subsequent disbursement of assets as they become available;

(c) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(d) The securing, by the liquidator, from each of the associations entitled to disbursements pursuant to this section, of an agreement to return to the liquidator such assets together with income earned on assets previously disbursed as may be required to pay claims of secured creditors and claims falling within the priorities established in section 10-3-541 in accordance with such priorities; and in such case, no bond shall be required of any such association; and

(e) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets, and any other matter as the court may direct.

(3) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator, and shall further provide that, if the assets available for disbursement from time to time do not equal or exceed the amount of such

claim payments made or to be made by the association, then disbursements shall be in the amount of available assets.

(4) The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the statutes creating such associations.

(5) Notice of the application referenced in subsection (1) of this section shall be given to the association in, and to the insurance departments of, each of the states having jurisdiction over any insurer affected by the liquidator's proposal. Any such notice shall be deemed to have been given when deposited in the United States certified mail, first-class postage prepaid, at least thirty days prior to submission of such application to the court. Action on the application may be taken by the court if such notice has been given and if the liquidator's proposal complies with the requirements of paragraphs (a) and (b) of subsection (2) of this section.

Source: L. 92: Entire part R&RE, p. 1467, § 14, effective July 1.

10-3-533.5. Sale of insolvent insurer as a going concern. (1) (a) The domiciliary receiver may apply to the court for permission to sell an insolvent domestic insurer as a going concern. If the court determines that the sale of the insurer as a going concern is in the best interest of the estate and that the sale will not diminish the value of the claims of shareholders and creditors, the court shall order that the insurer be discharged from all of its liabilities, that the outstanding shares of the insurer be canceled, that for no additional consideration new shares of the insurer be issued in the name of the receiver, that the receiver be vested with title to the new shares, which shares shall be deemed validly issued, fully paid, and nonassessable pursuant to applicable law, and that the receiver be authorized to sell the shares, together with such state or federal income or other tax credits or deductions of the insurer as the receiver determines to be in the best interest of the estate. Upon confirmation of the sale by the court, the purchasers of the shares shall be vested with title to those shares, including any such tax credits of the insurer, free and clear of all claims and defenses. The proceeds from the sale of the shares shall become a part of the general assets of the estate in liquidation.

(b) A sale under this section does not affect the rights and liabilities of the estate of the insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in the estate as fixed under section 10-3-541. No person is entitled to any priority or preference rights in the proceeds of the sale except as fixed under said section 10-3-541.

(c) As used in this section, "shares" has the same meaning as set forth in section 7-101-401 (31), C.R.S., and includes any secured party or other person or holder who has or claims to have any interest of any kind in any shares of the insurer.

(2) The enumeration of the powers and authority of the domiciliary receiver in this section shall not be construed as a limitation upon the receiver, nor shall it exclude in any manner the right to do such other acts not specifically enumerated in this section or otherwise provided for as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

(3) Nothing in this section shall be deemed a waiver of capitalization, surplus requirements, or any other condition of licensure imposed by this title for the issuance of a

certificate of authority to do insurance business or for the change in control of a foreign or domestic insurer.

(4) This section shall be liberally construed to accomplish its purpose to provide a more expeditious and effective procedure for marshaling the assets of the estate in order to realize the maximum amount possible from the sale of those assets and ensure that the purchasers receive clear and marketable titles.

Source: L. 92: Entire part R&RE, p. 1469, § 14, effective July 1. **L. 93:** (1)(c) amended, p. 859, § 21, effective July 1, 1994. **L. 2005:** (1)(c) amended, p. 762, § 13, effective June 1.

10-3-534. Filing of claims. (1) Proof of all claims shall be filed with the liquidator in the form required by section 10-3-535 on or before the last day for filing specified in the notice required under section 10-3-521; except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(2) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if the claimant's filing were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(a) A transfer to a creditor was avoided under sections 10-3-525 to 10-3-527, or was voluntarily surrendered under section 10-3-528, and the filing satisfies the conditions set forth in section 10-3-528; or

(b) The valuation, under section 10-3-540, of security held by a secured creditor shows a deficiency which is filed within thirty days after the valuation.

(3) The liquidator shall permit late-filed claims to share in distributions, whether past or future, as if they were not late, if such claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

Source: L. 92: Entire part R&RE, p. 1470, § 14, effective July 1.

10-3-535. Proof of claim. (1) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(a) The particulars of the claim, including the consideration given for it;

(b) The identity and amount of the security on the claim;

(c) The payments made on the debt, if any;

(d) That the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim;

(e) Any right of priority of payment or other specific right asserted by the claimant;

(f) A copy of the written instrument which is the foundation of the claim; and

(g) The name and address of the claimant and of the attorney, if any, who represents the claimant.

(2) No claim needs to be considered or allowed if it does not contain all the information specified in subsection (1) of this section which may be applicable. The liquidator may require

that a prescribed form be used, and may require that other information and documents be included.

(3) The liquidator may, at any time, request the claimant to present information or evidence supplementary to that required under subsection (1) of this section and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(4) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion, needs to be considered as evidence of liability or of quantum of damages. No judgment or order against an insured or the insurer entered within the four-month period immediately preceding the filing of the petition needs be considered as evidence of liability or of the quantum of damages.

(5) All claims of a guaranty association or foreign guaranty association shall be in such form and shall contain such substantiation as may be agreed to by the association and the liquidator.

Source: L. 92: Entire part R&RE, p. 1471, § 14, effective July 1.

10-3-536. Special claims. (1) The claim of a third party which is contingent only on such party's first obtaining a judgment against the insured shall be considered and allowed as though there were no such contingency.

(2) A claim may be allowed, even if contingent, if it is filed in accordance with section 10-3-534; and such claim may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(3) Claims that are due except for the passage of time shall be treated in the same manner as are absolute claims; except that such claims may be discounted at the legal rate of interest.

(4) Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under section 10-3-512 or 10-3-517.

Source: L. 92: Entire part R&RE, p. 1472, § 14, effective July 1.

10-3-537. Special provisions for third-party claims. (1) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(2) Whether or not the third party files a claim, the insured may file a claim on the insured's own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty days after mailing of the notice required by section 10-3-521, whichever is later, the insured is an unexcused late filer.

(3) The liquidator shall make recommendations to the court under section 10-3-541 for the allowance of an insured's claim under subsection (2) of this section after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense.

After allowance by the court, the liquidator shall withhold any dividends payable on the claim pending the outcome of litigation and negotiation with the insured. When appropriate, the liquidator shall reconsider the claim on the basis of additional information and amend the said recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in any recommendation as in its initial determination. The court may amend its allowance as it finds appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of the amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expense of defense, or the amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection (3) shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(4) If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection (3) of this section. If any insured's claim is subsequently reduced under subsection (3) of this section, the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection (4).

(5) No claim may be presented under this section if it is or may be covered by any guaranty association or foreign guaranty association.

Source: L. 92: Entire part R&RE, p. 1472, § 14, effective July 1.

10-3-538. Disputed claims. (1) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or the claimant's attorney by first-class mail at the address shown in the proof of claim. Within sixty days after the mailing of the notice, the claimant may file objections with the liquidator. If no such filing is made, the claimant may not further object to the determination.

(2) Whenever objections are filed with the liquidator and the liquidator does not alter the denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first-class mail to the claimant or the claimant's attorney and to any other persons directly affected, not less than ten days nor more than thirty days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee, who shall submit findings of fact along with a recommendation.

Source: L. 92: Entire part R&RE, p. 1473, § 14, effective July 1.

10-3-539. Claims of surety. Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person fails to prove and file that claim, such other person may do so in the creditor's name and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that the other person discharges the undertaking; except that, in the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to

any distribution until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by the creditor in trust for such other person. The term "other person", as used in this section, does not apply to a guaranty association or foreign guaranty association.

Source: L. 92: Entire part R&RE, p. 1474, § 14, effective July 1.

10-3-540. Secured creditors' claims. (1) The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(a) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditor; or

(b) By agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

(2) The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant surrenders the security to the liquidator, the entire claim shall be allowed as if unsecured.

Source: L. 92: Entire part R&RE, p. 1474, § 14, effective July 1.

10-3-540.5. Qualified financial contracts - definitions. (1) Notwithstanding any other provision of this section, including any other provision of this section permitting the modification of contracts, or other law of a state, a person shall not be stayed or prohibited from exercising:

(a) A contractual right to cause the termination, liquidation, acceleration, or close-out of obligations under or in connection with any netting agreement or qualified financial contract with an insurer because of:

(I) The insolvency, financial condition, or default of the insurer at any time, if the right is enforceable under applicable law other than this part 5; or

(II) The commencement of a formal delinquency proceeding under this part 5;

(b) Any right under a pledge, security, collateral, reimbursement, or guarantee agreement or arrangement or any other similar security agreement or arrangement or other credit enhancement relating to one or more netting agreements or qualified financial contracts;

(c) (I) Subject to subparagraph (II) of this paragraph (c), any right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with one or more qualified financial contracts where the counterparty or its guarantor is organized under the laws of the United States or a state or a foreign jurisdiction approved by the securities valuation office of the national association of insurance commissioners as eligible for netting.

(II) No setoff shall be allowed after the commencement of a delinquency proceeding under part 4 of this article in favor of any person if:

(A) The claim against the insurer is disallowed;

(B) The claim against the insurer was purchased by or transferred to the person on or after the filing of the receivership petition or within one hundred twenty days preceding the filing of the receivership petition;

(C) The obligation of the insurer is owed to an affiliate of the person or an entity other than the person, absent written assignment of the obligation made more than one hundred twenty days before the filing of the petition for receivership;

(D) The obligation of the person is owed to an affiliate of the insurer or an entity other than the insurer, absent written assignment of the obligation made more than one hundred twenty days before the filing of the petition for receivership;

(E) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution;

(F) The obligations between the person and the insurer arise out of transactions by which either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations. Notwithstanding this sub-subparagraph (F), the receiver may permit setoffs if, in the receiver's discretion, a setoff is appropriate because of specific circumstances relating to a transaction.

(G) The obligation of the person arises out of any avoidance action taken by the receiver; or

(H) The obligation of the insured is for the payment of earned premiums or retrospectively rated earned premiums.

(2) (a) If a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a proceeding under this section terminates, liquidates, closes out, or accelerates the agreement or contract, damages shall be measured as of the date or dates of termination, liquidation, close-out, or acceleration. The amount of a claim for damages must be actual direct compensatory damages calculated in accordance with subsection (6) of this section.

(b) Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application or petition has been filed under this section shall be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party, notwithstanding any provision in the netting agreement or qualified financial contract that provides that the nondefaulting party is not required to pay any net or settlement amount due to the defaulting party upon termination. Any limited two-way payment or first method provision in a netting agreement or qualified financial contract with an insurer that has defaulted shall be deemed to be a full two-way payment or second method provision as against the defaulting insurer. Any such property or amount is, except to the extent it is subject to one or more secondary liens or encumbrances or rights of netting or setoff, a general asset of the insurer.

(3) In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this part 5, the receiver shall either:

(a) Transfer to one party, other than an insurer subject to a proceeding under this part 5, all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding, including:

(I) All rights and obligations of each party under each netting agreement and qualified financial contract; and

(II) All property, including any guarantees or other credit enhancement, securing any claims of each party under each netting agreement and qualified financial contract; or

(b) Transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in paragraph (a) of this subsection (3) with respect to the counterparty and any affiliate of the counterparty.

(4) If a receiver for an insurer makes a transfer of one or more netting agreements or qualified financial contracts, the receiver shall use its best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer by 12 noon of the receiver's local time on the business day following the transfer. For purposes of this subsection (4), "business day" means a day other than a Saturday, Sunday, or any day on which either the New York stock exchange or the federal reserve bank of New York is closed.

(5) Notwithstanding any other provision of this part 5, a receiver shall not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract or any pledge, security, collateral, or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract, that is made before the commencement of a formal delinquency proceeding under this part 5. However, a transfer may be avoided under section 10-3-525 (1) if the transfer was made with actual intent to hinder, delay, or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

(6) (a) In exercising the rights of disaffirmance or repudiation of a receiver with respect to any netting agreement or qualified financial contract to which an insurer is a party, the receiver for the insurer shall either:

(I) Disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding; or

(II) Disaffirm or repudiate none of the netting agreements and qualified financial contracts referred to in subparagraph (I) of this paragraph (a) with respect to the person or any affiliate of the person.

(b) Notwithstanding any other provision of this part 5, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding conservation or rehabilitation case shall be determined and shall be allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a conservation or rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for conservation or rehabilitation. The amount of the claim is the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract. The term "actual direct compensatory damages" does not include punitive or exemplary damages, damages for lost profit or lost opportunity, or damages for pain and suffering, but does include normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives, securities, or other market for the contract and agreement claims.

(7) As used in this section:

(a) "Contractual right" includes any right set forth in a rule or bylaw of a derivatives clearing organization, as defined in the federal "Commodity Exchange Act", 7 U.S.C. sec. 1 et seq., a multilateral clearing organization, as defined in the "Federal Deposit Insurance

Corporation Improvement Act of 1991", Pub.L. 102-242, a national securities exchange, a national securities association, a securities clearing agency, a contract market designated under the federal "Commodity Exchange Act", a derivatives transaction execution facility registered under the federal "Commodity Exchange Act", or a board of trade as defined in the federal "Commodity Exchange Act", or in a resolution of the governing board of any of these entities and any right, whether or not evidenced in writing, arising under statutory or common law, under law merchant, or by reason of normal business practice.

(b) (I) "Qualified financial contract" means any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, and any similar agreement that the commissioner determines by rule or order to be a qualified financial contract for the purposes of this section.

(II) "Commodity contract" means:

(A) A contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade or contract market under the federal "Commodity Exchange Act", 7 U.S.C. sec. 1 et seq., or a board of trade outside the United States;

(B) An agreement that is subject to regulation under section 19 of the federal "Commodity Exchange Act", 7 U.S.C. sec. 1 et seq., and that is commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract;

(C) An agreement or transaction that is subject to regulation under section 4c (b) of the federal "Commodity Exchange Act", 7 U.S.C. sec. 1 et seq., and that is commonly known to the commodities trade as a commodity option;

(D) Any combination of the agreements or transactions referred to in this subparagraph (II); or

(E) Any option to enter into an agreement or transaction referred to in this subparagraph (II).

(III) "Forward contract", "repurchase agreement", "securities contract", and "swap agreement" have the meanings set forth in the "Federal Deposit Insurance Act", 12 U.S.C. sec. 1821 (e)(8)(D), as amended from time to time.

(8) This section does not apply to persons who are affiliates of the insurer that is the subject of the proceeding.

(9) All rights of counterparties under this part 5 apply to netting agreements and qualified financial contracts entered into on behalf of the general account or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

Source: L. 2014: Entire section added, (HB 14-1315), ch. 295, p. 1212, § 2, effective August 6.

10-3-541. Priority of distribution - definitions - repeal. (1) The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full, or adequate funds shall be retained for such payment, before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(a) **Class 1.** (I) The costs and expenses of administration during rehabilitation and liquidation, including but not limited to the following:

(A) The actual and necessary costs of preserving or recovering the assets of the insurer;

(B) Compensation for all authorized services rendered in the rehabilitation and liquidation;

(C) Any necessary filing fees;

(D) The fees and mileage payable to witnesses;

(E) Authorized reasonable attorney fees and fees for other professional services rendered in the rehabilitation and liquidation; and

(F) The administrative expenses of guaranty associations; and

(II) Claims by member insurers for their pro rata share of the risk adjustment program payable by an impaired insurer or insolvent insurer if the commissioner determines that the failure of the impaired insurer or insolvent insurer to pay such risk adjustment program payments would result in the impairment or insolvency of the claimant member insurer and that such impairment or insolvency would be avoided by payment of the claim. The amount of the payment of the claim must not exceed the lesser of:

(A) The pro rata amount the claimant member insurer would be entitled to from the risk adjustment program but did not receive because the estate of the impaired or insolvent insurer has not made the full payment; or

(B) The amount needed to avoid the claimant member insurer's impairment or insolvency.

(b) **Class 2.** All claims under policies including such claims of the federal or any state or local government including unearned premium claims, third-party claims, and all claims of a guaranty association or foreign guaranty association. That portion of any loss for which indemnification is provided by other benefits or advantages recovered by the claimant, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities, shall not be included in this class. No payment by an employer to the employer's employee shall be treated as a gratuity. All claims under life insurance and annuities policies and deposits, whether for death proceeds, annuity proceeds, or values, shall be treated as class 2 claims. For the purpose of this paragraph (b), policies shall include those insurance company products that are authorized under the laws of this state as such laws existed on the date of the issuance of such policies or on the date of the entry of an order of liquidation. Notwithstanding the provisions of this paragraph (b), class 2 claims shall not include:

(I) Claims under annuity and deposit contracts issued on or before August 15, 2000, however labeled, including labels such as annuity, deposit, financial guarantee, funding agreement, or guaranteed investment contract, unless the contract is:

(A) Issued to, or owned by, an individual or is otherwise an annuity issued in connection with and for the purpose of funding structured settlements of liability; or

(B) Issued to, for the benefit of, or in connection with, a specific employee benefit plan or governmental lottery;

(II) Claims where the risk is not borne by the insurer, such as the uninsured portion of:

(A) A minimum premium group insurance plan;

(B) A stop-loss group insurance plan; or

(C) An administrative-services only contract and the related uninsured plan liabilities;

(III) Claims under an unallocated annuity contract issued to an employee benefit plan protected under the federal pension benefit guaranty corporation; and

(IV) Claims for benefits which are exclusively payable or determined by a separate account required by the terms of such contract to be maintained by the insurer or a separate entity.

(c) (I) **Class 3.** Claims of the federal government, except those described in subsection (1)(b) of this section.

(II) On and after May 15, 2023, through June 30, 2026, class 3 claims include all claims owed for the risk adjustment program.

(d) **Class 4.** Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for services performed within the one-year period immediately preceding the filing of the petition for liquidation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

(e) **Class 5.** Claims of any state or local government except those under paragraph (b) of this subsection (1). Claims in this paragraph (e), including those of any governmental body for a penalty or forfeiture, shall be allowed only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose and for the reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to class 7.

(f) **Class 6.** Claims filed late and any other claims other than claims described in paragraph (h) of this subsection (1).

(g) **Class 7.** Surplus or contribution notes or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(h) **Class 8.** Claims of shareholders or other owners in their capacity as shareholders.

(2) (a) (Deleted by amendment, L. 2003, p. 2045, § 2, effective May 22, 2003.)

(b) Every claim under a separate account contract providing, in effect, that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurer shall be satisfied out of the assets in the separate account equal to the reserves and other contract liabilities maintained in such account for such contract. To the extent, if any, that the separate account assets are not sufficient to discharge such claims due to fraud, error, or other malfeasance on the part of the insurer or if unsatisfied claims arise from a contractual guarantee made to a contract holder by the insurer's general account, such unsatisfied claims shall be treated as a class 2 claim against the insurer's estate. Any such class 2 claim shall be subject to the applicable exceptions for this class, excluding the exception for separate accounts under subparagraph (IV) of paragraph (b) of subsection (1) of this section.

(2.5) The commissioner shall order a member insurer that received payments pursuant to subsection (1)(a)(II) of this section to refund to the estate of an impaired insurer or insolvent insurer any amounts received pursuant to subsection (1)(a)(II) of this section that duplicate payments the member insurer received from the risk adjustment program.

(3) As used in this section:

(a) "Impaired insurer" has the same meaning as set forth in section 10-20-103 (6.7).

(b) "Insolvent insurer" has the same meaning as set forth in section 10-20-103 (7).

(c) "Insurer's estate" or "estate" means the general assets of such insurer less any assets held in separate accounts that, pursuant to section 10-7-402, are not chargeable with liabilities arising out of any other business of the insurer. To the extent, if any, assets maintained in the separate account are in excess of the amounts needed to satisfy claims under the separate account contracts, the excess shall be treated as part of the insurer's estate.

(d) "Member insurer" has the same meaning as set forth in section 10-20-103 (8).

(e) "Risk adjustment program" means the program established pursuant to section 1343 of the federal "Patient Protection and Affordable Care Act", Pub.L. 111-148, as amended by the federal "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152, and as may be further amended, 42 U.S.C. sec. 18063, to provide payments to health insurance carriers that cover high-risk populations and to more evenly distribute the financial risk borne by carriers.

(f) "Separate account contract" means any life policy or contract, annuity contract, funding agreement, or guaranteed investment contract providing for the allocation of amounts received in connection with such policy, contract, or agreement to a separate account authorized by section 10-7-402.

(4) Subsections (1)(a)(II), (1)(c)(II), (2.5), (3)(a), (3)(b), (3)(d), and (3)(e) of this section and this subsection (4) are repealed, effective July 1, 2026.

Source: L. 92: (1)(c) amended, p. 1552, § 48, effective May 20; entire part R&RE, p. 1474, § 14, effective July 1. **L. 96:** Entire section amended, p. 174, § 1, effective April 8. **L. 97:** (1)(b)(I)(A) amended and (2) added, p. 360, § 1, effective August 6. **L. 2000:** IP(1)(b) and IP(1)(b)(I) amended, p. 1733, § 6, effective August 15. **L. 2003:** (2)(a) amended and (3) added, p. 2045, § 2, effective May 22. **L. 2023:** (1)(a), (1)(c), and (3) amended and (2.5) and (4) added, (HB 23-1303), ch. 195, p. 976, § 1, effective May 15.

Editor's note: Although the effective date for the repeal and reenactment of this part 5 was July 1, 1992, the act further amending subsection (1)(c) was effective May 20, 1992.

10-3-542. Liquidator's recommendations to the court. (1) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as deemed necessary. The liquidator may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court except where the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under section 10-3-538. As soon as practicable, the liquidator shall present to the court a report of the claims against the insurer with the liquidator's recommendations. The report shall include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(2) The court may approve, disapprove, or modify the liquidator's report on claims. Claims allowed in any report not modified by the court within a period of sixty days after submission by the liquidator shall be treated by the liquidator as allowed claims, subject thereafter to later modification or to rulings made by the court pursuant to section 10-3-538. No

claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

Source: L. 92: Entire part R&RE, p. 1476, § 14, effective July 1.

10-3-543. Distribution of assets. Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

Source: L. 92: Entire part R&RE, p. 1477, § 14, effective July 1.

10-3-544. Unclaimed and withheld funds. (1) All unclaimed funds subject to distribution remaining in the liquidator's hands when the liquidator is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the state treasurer and shall be paid, without interest, except in accordance with section 10-3-541, to the person entitled thereto or such person's legal representative upon proof satisfactory to the state treasurer of the person's right thereto. Any amount on deposit not claimed within six years after the date of discharge of the liquidator shall be deemed to have been abandoned and shall escheat, without formal escheat proceedings, to the state and shall be deposited in the general fund.

(2) All funds withheld under section 10-3-537 and not distributed shall, upon discharge of the liquidator, be deposited with the state treasurer and paid in accordance with section 10-3-541. Any sums remaining which, under section 10-3-541, would revert to the undistributed assets of the insurer shall be transferred to the state treasurer and become the property of the state under subsection (1) of this section unless the commissioner in the commissioner's discretion petitions the court to reopen the liquidation under section 10-3-546.

Source: L. 92: Entire part R&RE, p. 1477, § 14, effective July 1.

10-3-545. Termination of proceedings. (1) When all assets justifying the expense of collection and distribution have been collected and distributed under this part 5, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, as may be deemed appropriate.

(2) Any other person may apply to the court at any time for an order under subsection (1) of this section. If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney fee.

Source: L. 92: Entire part R&RE, p. 1477, § 14, effective July 1.

10-3-546. Reopening liquidation. After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time

petition the district court in and for the city and county of Denver to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

Source: L. 92: Entire part R&RE, p. 1478, § 14, effective July 1.

10-3-547. Disposition of records during and after termination of liquidation. Whenever it appears to the commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, the commissioner may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed.

Source: L. 92: Entire part R&RE, p. 1478, § 14, effective July 1.

10-3-548. External audit of receiver's books. The district court in and for the city and county of Denver may, as it deems desirable, cause audits to be made of the books of the commissioner relating to any receivership established under this part 5, and a report of each such audit shall be filed with the commissioner and with the court. The books, records, and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

Source: L. 92: Entire part R&RE, p. 1478, § 14, effective July 1.

10-3-549. Conservation of property of foreign or alien insurers found in this state. (1) If a domiciliary liquidator has not been appointed, the commissioner may apply to the district court in and for the city and county of Denver by verified petition for an order directing the commissioner to act as conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

(a) Any of the grounds set forth in section 10-3-511;

(b) That any of the insurer's property has been sequestered by official action in its domiciliary state or in any other state;

(c) That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent;

(d) That its certificate of authority to do business in this state has been revoked or that none was ever issued and that there are residents of this state with outstanding claims or outstanding policies.

(2) When an order is sought under subsection (1) of this section, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) The court may issue the order in whatever terms it deems appropriate. The filing or recording of the order with the clerk of the said court or with the recorder of deeds of the county in which the principal business of the company is located shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds.

(4) The conservator may at any time petition for, and the court may grant, an order under section 10-3-550 to liquidate assets of a foreign or alien insurer under conservation, or, if appropriate, for appointment as ancillary receiver under section 10-3-552.

(5) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party. If such motion by any person other than the conservator is denied, all costs of such motion shall be assessed against the movant.

Source: L. 92: Entire part R&RE, p. 1478, § 14, effective July 1.

10-3-550. Liquidation of property of foreign or alien insurers found in this state. (1) If no domiciliary receiver has been appointed, the commissioner may apply to the district court in and for the city and county of Denver by verified petition for an order directing the commissioner to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the grounds specified in section 10-3-511 or 10-3-516 or any of the grounds specified in section 10-3-549 (1)(b) to (1)(d).

(2) When an order is sought under subsection (1) of this section, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) If it appears to the court that the best interests of creditors, policyholders, and the public so require, the court may issue an order to liquidate in whatever terms it deems appropriate. The filing or recording of the order with the clerk of the said court or with the recorder of deeds of the county in which the principal business of the company is located or the county in which its principal office or place of business is located shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded with such recorder of deeds.

(4) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under section 10-3-552. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under section 10-3-552.

(5) On the same grounds as are specified in subsection (1) of this section, the commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or over any lesser part thereof that the commissioner deems desirable for the protection of the policyholders and creditors in this state.

(6) The court may order the commissioner, when the commissioner has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under such rules governing the liquidation of insurers under this part 5 as are otherwise compatible with the provisions of this section.

Source: L. 92: Entire part R&RE, p. 1479, § 14, effective July 1.

10-3-551. Domiciliary liquidators in other states. (1) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall be vested, except as to special deposits and security on secured claims under section 10-3-552 (3), by operation of law with the title to all of the assets, property, contracts, rights of action, and agents' balances and all of the books, accounts, and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state; otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts, and other records of the insurer located in this state, and shall also, subject to the provisions of section 10-3-552, have the right to recover all other assets of the insurer located in this state.

(2) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this state shall be vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books, accounts, and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The commissioner of this state may petition for a conservation or liquidation order under section 10-3-549 or 10-3-550 or for an ancillary receivership under section 10-3-552, or, after approval by the district court in and for the city and county of Denver, may transfer title to the domiciliary liquidator as the interests of justice and the equitable distribution of the assets require.

(3) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. Such claims shall be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

Source: L. 92: Entire part R&RE, p. 1480, § 14, effective July 1.

10-3-552. Ancillary formal proceedings. (1) If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the commissioner may file a petition with the district court in and for the city and county of Denver requesting appointment as ancillary receiver in this state:

(a) If the commissioner finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver; or

(b) If the protection of creditors or policyholders in this state so requires.

(2) The court may issue an order appointing an ancillary receiver in whatever terms it deems appropriate. The filing or recording of the order with a recorder of deeds in this state imparts the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded with such recorder of deeds.

(3) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as is practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. The ancillary receiver shall also promptly transfer all remaining assets, books, accounts, and records to the domiciliary liquidator. Subject

to this section, the ancillary receiver and such ancillary receiver's deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

(4) When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, rights, duties, and powers corresponding to those provided in subsection (3) of this section for ancillary receivers appointed in this state.

Source: L. 92: Entire part R&RE, p. 1481, § 14, effective July 1.

10-3-553. Ancillary summary proceedings. The commissioner, in the commissioner's sole discretion, may institute proceedings under sections 10-3-509 and 10-3-510 at the request of the insurance department of the domiciliary state of any foreign or alien insurer having property located in this state.

Source: L. 92: Entire part R&RE, p. 1482, § 14, effective July 1.

10-3-554. Claims of nonresidents against insurers domiciled in this state. (1) In a liquidation proceeding commenced in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states that are not reciprocal states must file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, if a claim filing procedure is established in the ancillary proceeding, or with the domiciliary liquidator. Such claims shall be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in this part 5, or in ancillary proceedings, if any, in the reciprocal states if a claim filing procedure is established in the ancillary proceeding. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in section 10-3-555 (2) with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under section 10-3-541.

Source: L. 92: Entire part R&RE, p. 1482, § 14, effective July 1.

Editor's note: This section is similar to former § 10-3-505 as it existed prior to 1992.

10-3-555. Claims of residents against insurers domiciled in reciprocal states. (1) Promptly after the appointment of the commissioner as ancillary receiver for an insurer not domiciled in this state, the commissioner shall determine whether there are claimants residing in this state who are not protected by guaranty funds and, if so, whether the protection of such claimants requires the establishing of a claim filing procedure in the ancillary proceeding. If a claim filing procedure is established, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state, or with the domiciliary

liquidator. Such claims shall be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state if a claim filing procedure is established in such ancillary proceeding. If a claimant elects to prove such a claim in this state, the claimant shall file the claim with the liquidator in the manner provided in sections 10-3-534 and 10-3-535. The ancillary receiver shall make a recommendation to the court as under section 10-3-542 and shall also arrange a date for hearing if necessary under section 10-3-538 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service, at least forty days prior to the date set for hearing. If the domiciliary liquidator, within thirty days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of the domiciliary liquidator's intention to contest the claim, the domiciliary liquidator shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(3) The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

Source: L. 92: Entire part R&RE, p. 1483, § 14, effective July 1.

Editor's note: This section is similar to former § 10-3-506 as it existed prior to 1992.

10-3-556. Attachment, garnishment, and levy of execution. During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment, or levy of execution shall be commenced or maintained in this state against the delinquent insurer or its assets.

Source: L. 92: Entire part R&RE, p. 1483, § 14, effective July 1.

Editor's note: This section is similar to former § 10-3-510 as it existed prior to 1992.

10-3-557. Interstate priorities. (1) In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

(2) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, as well as all claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(3) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender the security and file the claim as a general creditor. Alternatively, the claim may be discharged by resort to the security in accordance with section 10-3-540, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

Source: L. 92: Entire part R&RE, p. 1484, § 14, effective July 1.

10-3-558. Subordination of claims for noncooperation. If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within such receiver's control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class 7 as defined in section 10-3-541 (1)(g).

Source: L. 92: Entire part R&RE, p. 1484, § 14, effective July 1.

10-3-559. Severability. If any provision of this part 5 or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this part 5 and the application of such provision to other persons or circumstances shall not be affected thereby.

Source: L. 92: Entire part R&RE, p. 1484, § 14, effective July 1.

PART 6

EXCHANGE OF INSURANCE SECURITIES ACT

10-3-601. Short title. This part 6 shall be known and may be cited as the "Colorado Exchange of Insurance Securities Act".

Source: L. 69: p. 529, § 1. **C.R.S. 1963:** § 72-27-1.

10-3-601.5. Definitions. As used in this part 6, unless the context otherwise requires:

(1) "Acquiring corporation" means:

(a) Any stock insurance company organized under the laws of this state, other than the domestic company whose shareholders are to exchange their stock under a plan of exchange, as provided in this part 6; or

(b) Any stock corporation organized under the "Colorado Corporation Code" which is not an insurance company; or

(c) Any stock corporation which is not an insurance company and which was organized under any general law of this state prior to the effective date of the "Colorado Corporation Code" (January 1, 1959) and to which such code is applicable; or

(d) Any stock corporation organized under the laws of any state of the United States, whether or not an insurance company.

(2) "Domestic company" means a stock insurance company organized under the laws of this state.

Source: L. 2025: Entire section added with relocations, (SB 25-275), ch. 377, p. 2036, § 38, effective August 6.

Editor's note: Subsection (1) is similar to former § 10-3-603 as it existed prior to 2025.

10-3-602. Exchange of securities. (1) A domestic company may adopt a plan of exchange providing for the exchange by its shareholders of their stock in the domestic company for:

(a) Shares of stock issued by an acquiring corporation; or
(b) Other securities issued by an acquiring corporation; or
(c) Cash; or
(d) Other consideration; or
(e) Any combination of such stock, other securities, cash, or other consideration.

Source: L. 69: p. 529, § 2. **C.R.S. 1963:** § 72-27-2. **L. 2025:** IP(1) amended, (SB 25-275), ch. 377, p. 2036, § 39, effective August 6.

10-3-603. Acquiring corporation - definition. (Repealed)

Source: L. 69: p. 529, § 3. **C.R.S. 1963:** § 72-27-3. **L. 2025:** Entire section repealed, (SB 25-275), ch. 377, p. 2109, § 336, effective August 6.

Editor's note: This section was relocated to § 10-3-601.5 (1) in 2025.

10-3-604. Procedure for exchange. (1) Any domestic company may adopt a plan of exchange with any acquiring corporation providing for the exchange of the outstanding stock of the domestic company for shares of stock or other securities issued by the acquiring corporation, or cash, or other consideration, or any combination thereof, in the following manner:

(a) The boards of directors of the domestic company and of the acquiring corporation, by resolutions approved by a majority of the whole of each such board, shall adopt a plan of exchange which shall set forth the terms and conditions of the exchange and the mode of carrying the same into effect and such other provisions with respect to the exchange as may be deemed necessary or desirable.

(b) The domestic company and the acquiring corporation shall submit to the commissioner three copies of the plan of exchange certified by an officer of each as having been adopted in accordance with paragraph (a) of this subsection (1). Such copies of the plan of exchange shall be accompanied by:

(I) The annual statement of the domestic company for its last preceding calendar year prepared pursuant to section 10-3-208;

(II) Fully audited financial information as to the earnings and financial condition of the acquiring corporation for the preceding five fiscal years of each such acquiring corporation, or for lesser period as such acquiring corporation and any predecessors thereof have been in

existence, and similar unaudited information as of a date not earlier than ninety days prior to the date of filing the statement;

(III) A pro forma financial statement of each acquiring corporation based on the assumption that the plan of exchange was effective as proposed at the end of the last preceding calendar year of the domestic company;

(IV) An estimate of expenses already incurred and expenses expected to be incurred in connection with the proposed plan of exchange;

(V) A written statement which sets forth for each corporation the proposed changes, if any, in management policies and the identity of officers and directors of the domestic company and of the acquiring corporation which are initially contemplated should the plan of exchange be effective as proposed; and

(VI) If the plan of exchange is submitted to the commissioner after March 31 of any year, a balance sheet of the domestic company, as of a date within ninety days prior to the date the plan is submitted, a summary of operations of the domestic company for the period between the preceding December 31 and the date of such balance sheet, and financial statements of each acquiring corporation based on the assumption that the plan of exchange was effective as proposed on the date of such balance sheet.

(c) The commissioner shall hold a hearing upon the fairness of: The terms, conditions, and provisions of the plan of exchange; and the proposed exchange of stock or other securities of the acquiring corporation, or cash, or other consideration, or any combination thereof, for the stock of the domestic company, at which hearing the policyholders and the shareholders of both the domestic company and the acquiring corporation and any other interested party shall have the right to appear and to become party to the proceeding. The commissioner shall require the domestic company and the acquiring corporation to produce such evidence as he deems necessary to establish the fairness to be ascertained at the hearing, including in any event evidence concerning the valuation of the respective companies and the method utilized by the management of each corporation to accomplish such valuation, inclusive of the value established with respect to the stock of the domestic company which is proposed to be exchanged, as well as the value of the stock, securities, and consideration, other than cash, to be offered by the acquiring corporation in such exchange.

(d) Such hearing shall be commenced not less than twenty days after the date on which the plan of exchange is presented to the commissioner. The hearing shall be held in the city and county of Denver at such place, date, and time as the commissioner specifies. Notice of the hearing shall be published in a newspaper of general circulation in the city wherein is located the principal office of the domestic company and of the acquiring corporation, and in the city and county of Denver, once a week for two successive weeks. Written notice of the hearing shall be mailed at least ten days prior to the hearing by the domestic company and by the acquiring corporation to all of their respective shareholders. All expenses of publication shall be borne by the domestic company or the acquiring corporation, or both, as specified in the plan of exchange. The hearing shall be conducted in accordance with the provisions of section 24-4-105, C.R.S.

(e) The commissioner shall issue an order approving the plan of exchange as delivered to him by the domestic company and the acquiring corporation and such modifications therein as a majority of the whole board of directors of each such corporation approves if he finds: That the plan, including all such modifications, if effected, will not tend adversely to affect the financial stability or management of the domestic company or the general capacity or intention to

continue the safe and prudent transaction of the insurance business of the domestic company or of the acquiring corporation if it is a domestic insurance company; that the interests of the policyholders and shareholders of the domestic company and, if the acquiring corporation is a domestic insurance company, the policyholders of the acquiring corporation are adequately protected; that the fulfillment of the plan will not affect either the contractual obligations of the domestic company and of the acquiring corporation, if it is a domestic insurance company, to its policyholders or the ability and tendency of either to render service to its policyholders in the future; that the effect of the merger or other acquisition of control would not substantially lessen competition in the business of providing insurance in this state or tend to create a monopoly therein; that all plans or proposals which the acquiring corporation has to liquidate the domestic company or to sell its assets, consolidate or merge it with any person, or make any other material change in its business or corporate structure or management have been fully disclosed and are not unfair or unreasonable to policyholders of the domestic company and are in the public interest; that the competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would be in the interest of the policyholders of the domestic company and of the public to permit the merger or other acquisition of control; and that the terms and conditions of the plan of exchange and the proposed issuance and exchange are otherwise fair and reasonable.

(f) The order of the commissioner approving or disapproving the plan of exchange shall be filed in his office within sixty days after the date the plan of exchange is presented to him. Upon filing such order, the commissioner shall send a copy thereof to each party to the proceeding, such copy to be sent to each such party by certified mail directed to such party at the address of such party as shown by the record of the hearing. Any final order of the commissioner approving or disapproving a plan of exchange pursuant to this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

(g) The plan of exchange as approved by the commissioner shall be submitted to a vote of the shareholders of the domestic company at an annual or special meeting of the shareholders. Notice of the submission of the plan to the shareholders shall be included in the notice of the meeting. The plan shall be approved by the shareholders of the domestic company upon receiving the affirmative votes of the holders of shares of the domestic company having at least two-thirds of the total voting power of the outstanding shares of the domestic company. Notwithstanding shareholder approval of the plan of exchange, and at any time prior to the filing of the certificate setting forth the plan of exchange by the commissioner pursuant to section 10-3-605, the plan of exchange may be abandoned pursuant to a provision for such abandonment, if any, contained in the plan of exchange.

(h) Within ten days after the plan of exchange is approved by the shareholders of the domestic company, a written notice of the approval of the plan of exchange shall be mailed or delivered personally to each shareholder of record of such company who was entitled to vote thereon. The domestic company shall thereafter file with the commissioner an affidavit of the secretary or an assistant secretary of such company, or of an officer of the transfer agent of such company, that such notice was given.

(i) Any shareholder of the domestic company owning shares not voted in favor of such plan at the meeting at which the plan was approved by the shareholders of the domestic company may object in writing to the plan and demand payment, should the plan become effective, of the fair value of any of such shares, as of the day on which the plan of exchange was approved by

the shareholders of the domestic company pursuant to paragraph (g) of this subsection (1). Such objection and demand shall be received, together with the certificate representing the shares with respect to which objection and demand have been made, for notation thereon that such objection and demand have been made, by the domestic company or its transfer agent within thirty days after the date of said meeting of shareholders. No such objection and demand shall pertain to any shares which were voted in favor of the plan. No such objection and demand may be withdrawn unless the domestic company, by a duly authorized officer, consents thereto in writing.

(j) Upon the plan of exchange becoming effective, the holder of any shares, with respect to which such objection and demand have been made and certificates for which have been delivered to the domestic company or its transfer agent for notation, or any transferee thereof, shall cease to be a shareholder of the domestic company with respect to such shares and shall have no rights with respect to such shares, except the right to receive payment therefor in accordance with the provisions of paragraph (k) of this subsection (1). Every shareholder failing to make objection and demand accompanied by certificates representing the shares with respect to which such objection and demand have been made or withdrawing such objection and demand as provided in paragraph (i) of this subsection (1) shall be conclusively presumed to have assented to, and to have agreed to be bound by, the plan of exchange in accordance with its terms.

(k) Within forty-five days after the date of the meeting of shareholders of the domestic company at which the plan of exchange was approved by such shareholders, the domestic company, or, if the plan of exchange so specifies, the acquiring corporation, shall mail a written offer to each holder of record of shares with respect to which an objection and demand have been made, as provided in paragraph (i) of this subsection (1), to pay for such shares a price per share deemed by such corporation to be the fair value thereof as of the date of such meeting. The form of written offer to be used, including the price per share, shall first be submitted to and approved by the commissioner. If such offer is accepted in writing by such holder, such corporation shall pay such holder, within forty-five days after the date of the plan of exchange becoming effective, such price upon the surrender of the certificate representing such shares.

(l) If, within thirty days after the date of the mailing of such written offer, the domestic company or the acquiring corporation, as the case may be, and a shareholder do not agree on the price, such corporation or the shareholder may, within ninety days after the date of the mailing of such written offer, file a petition in any court of competent jurisdiction in the county where the registered office of the domestic company is located asking for a finding and determination of the fair value of such shares as of the date of the meeting of shareholders of the domestic company at which the plan of exchange was approved by such shareholders; and payment of the fair value thereof shall be made by the domestic company or, if the plan of exchange so specifies, the acquiring corporation within sixty days after the entry of the judgment or order determining such fair value, upon the surrender of the certificate representing such shares.

(m) All shares acquired by the domestic company, upon payment of the value therefor, shall be canceled by the board of directors of the domestic company, upon the plan of exchange becoming effective, or at any time thereafter in the manner provided in section 7-106-302 (2)(b), C.R.S., and any statement of cancellation made pursuant to said section shall first be filed with the commissioner prior to filing thereof with the secretary of state. If the commissioner finds such statement of cancellation to have been lawfully executed, and to be in due legal form and

not in conflict with the provisions of law governing the domestic company, such statement of cancellation shall be filed with the secretary of state.

(n) If the plan of exchange does not become effective, the right of shareholders or transferees to be paid the fair value of their shares under this subsection (1) shall cease, and their status shall be the same as that of shareholders who voted in favor of the plan. If a shareholder or his transferee, with respect to any share for which objection and demand have been made: Withdraws such objection and demand in the manner provided by this subsection (1), or fails to submit a certificate at the time and in the manner required by this subsection (1), or does not file a petition for the determination of fair value within the time and in the manner provided in this subsection (1) and neither the domestic company nor the acquiring corporation files a petition for such determination, or is adjudged by a court of competent jurisdiction not to be entitled to the relief provided by this subsection (1), then the right of the shareholder or his transferee to be paid the fair value of such share shall cease, and his status with respect to such share shall be the same as that of a shareholder who voted in favor of the plan.

Source: L. 69: p. 529, § 4. **C.R.S. 1963:** § 72-27-4. **L. 77:** (1)(b) R&RE, p. 508, § 1, and (1)(e) amended, p. 509, § 2, effective June 3. **L. 92:** (1)(f) amended, p. 1553, § 49, effective May 20. **L. 93:** (1)(m) amended, p. 859, § 22, effective July 1, 1994.

Cross references: For annual financial statements, see § 10-3-208.

10-3-605. Filing plan of exchange. Not earlier than thirty-one days after the date of the meeting of shareholders of the domestic company at which the plan of exchange was approved by such shareholders, a certificate setting forth the plan of exchange, the manner of the approval thereof by the directors of the acquiring corporation and the domestic company, and the manner of its approval by the shareholders of the domestic company and the vote by which approved by the shareholders of the domestic company, or setting forth that the plan of exchange has been abandoned, shall be signed on behalf of each such corporation by its president or a vice-president and shall then be presented in triplicate to the commissioner at his office for filing. The commissioner shall file one copy of such certificate in his office and shall deliver copies bearing the date and time of filing endorsed thereon to the domestic company and the acquiring corporation. Upon the filing of such certificate, unless it sets forth that the plan of exchange has been abandoned, the plan of exchange and the issuance and exchange provided for therein shall become effective, unless a later date and time is specified in the plan of exchange, in which event the plan of exchange and the issuance and exchange provided for therein shall become effective upon such later date and time.

Source: L. 69: p. 533, § 5. **C.R.S. 1963:** § 72-27-5.

10-3-606. Effect of exchange. (1) Upon the plan of exchange becoming effective, the exchange provided for therein shall be deemed to have been consummated, each shareholder of the domestic company shall cease to be a shareholder of such company, the ownership of all shares of the issued and outstanding stock of the domestic company, except shares payment of the value of which is required to be made by the domestic company or the acquiring corporation pursuant to section 10-3-604, shall vest in the acquiring corporation automatically without any

physical transfer or deposit of certificates representing such shares, and all shares payment of the value of which is required to be made by the domestic company or the acquiring corporation pursuant to section 10-3-604, shall be deemed no longer outstanding shares of the domestic company.

(2) Certificates representing shares of the domestic company prior to the plan of exchange becoming effective, except certificates representing shares payment of the value of which is required to be made pursuant to section 10-3-604, and bearing a notation thereon that objection and demand pursuant to such section have been made, shall, after the plan of exchange becomes effective, represent: Shares of the issued and outstanding capital stock or other securities issued by the acquiring corporation; and the right, if any, to receive such cash or other consideration upon such terms as are specified in the plan of exchange; but the plan of exchange may specify that all certificates representing shares of stock of the domestic company, except certificates representing shares payment of the value of which is required to be made pursuant to section 10-3-604, shall, after the plan of exchange becomes effective, represent only the right to receive shares of stock or other securities issued by the acquiring corporation, or cash, or other consideration, or any combination thereof, upon such terms as are specified in the plan of exchange. Certificates representing shares of the domestic company with respect to which an objection and demand have been made pursuant to section 10-3-604, and bearing a notation thereon that such objection and demand have been made, shall, after the plan of exchange becomes effective, represent only the right to receive payment therefor, subject to the provisions of this part 6.

Source: L. 69: p. 533, § 6. **C.R.S. 1963:** § 72-27-6.

10-3-607. Authorized insurance business and regulatory authority. Nothing contained in this part 6 shall be construed to authorize any insurance company to engage in any kind of insurance business not authorized by its articles of incorporation or to authorize any acquiring corporation which is not an insurance company to engage directly in the business of insurance.

Source: L. 69: p. 534, § 7. **C.R.S. 1963:** § 72-27-7.

10-3-608. Domestic company and acquiring corporation separate and distinct entities. The domestic company and the acquiring corporation shall in all respects be regarded in law as separate and distinct corporations, with neither of such corporations having any liability to the creditors, policyholders, if any, or shareholders of the other, any acts or omissions of the officers, directors, or shareholders of either or both of such corporations notwithstanding.

Source: L. 69: p. 534, § 8. **C.R.S. 1963:** § 72-27-8.

10-3-609. Examination. After any acquiring corporation becomes the owner of all the outstanding shares of a domestic company pursuant to a plan of exchange consummated under the provisions of this part 6, the commissioner may, in connection with any examination of the domestic company, examine all records and documents of the acquiring corporation pertaining to the relationships and transactions of the domestic company with the acquiring corporation or its

subsidiaries or affiliates. If the acquiring corporation is organized under the laws of any state other than Colorado, the commissioner may, as a condition of approving the plan of exchange, require such acquiring corporation to file a written consent to examination of its records and documents as provided in this section.

Source: L. 69: p. 534, § 9. **C.R.S. 1963:** § 72-27-9.

10-3-610. Application of this part 6. Nothing contained in this part 6 shall be construed to prohibit the consummation of a plan of exchange of the kind described in section 10-3-602, without compliance with the provisions of this part 6, and, if any such plan of exchange is consummated other than in compliance with this part 6, none of the provisions of sections 10-3-604 to 10-3-606 shall be applicable to such plan of exchange.

Source: L. 69: p. 534, § 10. **C.R.S. 1963:** § 72-27-10.

PART 7

CREDIT FOR REINSURANCE MODEL ACT

Editor's note: This part 7 was numbered as article 31 of chapter 72, C.R.S. 1963. It was repealed and reenacted in 2014, effective January 1, 2015, resulting in the addition, relocation, or elimination of sections as well as subject matter. For amendments to this part 7 prior to 2015, consult the 2014 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

10-3-701. Purpose. The purpose of this part 7 is to protect the interest of insureds, claimants, ceding insurers, assuming insurers, and the public generally. The general assembly hereby declares its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the general assembly hereby provides a mandate that upon the insolvency of a non-United States insurer or reinsurer that provides security to fund its United States obligations in accordance with this part 7, the assets representing the security must be maintained in the United States, claims must be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets must be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The general assembly declares that the matters contained in this part 7 are fundamental to the business of insurance in accordance with 15 U.S.C. secs. 1011 and 1012.

Source: L. 2014: Entire part R&RE, (HB 14-1315), ch. 295, p. 1201, § 1, effective January 1, 2015.

10-3-702. Credit allowed to a domestic ceding insurer - rules - definitions. (1) Credit for reinsurance shall be allowed to a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of

subsection (2), (3), (4), (5), (6), (6.5), or (7) of this section. Credit shall be allowed under subsection (2), (3), or (4) of this section only as respects cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under subsection (4) or (5) of this section only if the applicable requirements of subsection (8) of this section have been satisfied.

(2) Credit shall be allowed to a domestic ceding insurer when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(3) Credit shall be allowed to a domestic ceding insurer when the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state. In order to be eligible for accreditation, a reinsurer must:

(a) File with the commissioner evidence of its submission to this state's jurisdiction;

(b) Submit to this state's authority to examine its books and records;

(c) Be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;

(d) File annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(e) Demonstrate to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet the requirement of this paragraph (e) as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than twenty million dollars and the commissioner has not denied its accreditation within ninety days after submission of its application.

(4) (a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this part 7 and the assuming insurer or United States branch of an alien assuming insurer:

(I) Maintains a surplus as regards policyholders in an amount not less than twenty million dollars; and

(II) Submits to the authority of this state to examine its books and records.

(b) The requirement of subparagraph (I) of paragraph (a) of this subsection (4) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(5) (a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in section 10-3-704 (2), for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the national association of insurance commissioners' annual statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the commissioner and bear the expense of examination.

(b) (I) Credit for reinsurance shall not be granted under this subsection (5) unless the form of the trust and any amendments to the trust have been approved by:

(A) The commissioner of the state where the trust is domiciled; or

(B) The commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(II) The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the commissioner.

(III) The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year, the trustee of the trust shall report to the commissioner in writing the balance of the trust and list the trust's investments at the preceding year's end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire before the following December 31.

(c) The following requirements apply to the following categories of assuming insurer:

(I) The trust fund for a single assuming insurer must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars, except as provided in subparagraph (II) of this paragraph (c).

(II) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and must consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus shall not be reduced to an amount less than thirty percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(III) (A) In the case of a group including incorporated and individual unincorporated underwriters: For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after January 1, 1993, the trust must consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group; for reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this part 7, the trust must consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the

United States; and, in addition to these trusts, the group shall maintain in trust a trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(B) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(C) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(IV) In the case of a group of incorporated underwriters under common administration, the group:

(A) Must have continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation;

(B) Shall maintain aggregate policyholders' surplus of at least ten billion dollars;

(C) Shall maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

(D) In addition, shall maintain a joint trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of United States domiciled ceding insurers of any member of the group as additional security for these liabilities; and

(E) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, shall make available to the commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

(6) (a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this subsection (6).

(b) In order to be eligible for certification, the assuming insurer must meet the following requirements:

(I) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to paragraph (d) of this subsection (6).

(II) The assuming insurer must maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner pursuant to rule.

(III) The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner pursuant to rule.

(IV) The assuming insurer must agree to submit to the jurisdiction of this state, appoint the commissioner as its agent for service of process in this state, and agree to provide security for one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment.

(V) The assuming insurer must agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis.

(VI) The assuming insurer must satisfy any other requirements for certification deemed relevant by the commissioner.

(c) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying the requirements of paragraph (b) of this subsection (6):

(I) The association must satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which must include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the commissioner to provide adequate protection;

(II) The incorporated members of the association must not be engaged in any business other than underwriting as a member of the association and are subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(III) Within ninety days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(d) (I) The commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

(II) In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction must agree in writing to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction shall not be recognized as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the commissioner.

(III) The commissioner may consider a list of qualified jurisdictions published by the national association of insurance commissioners' committee process in determining qualified jurisdictions for purposes of this section. If the commissioner approves a jurisdiction as qualified that does not appear on the national association of insurance commissioners' list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification in accordance with criteria to be specified in rules promulgated by the commissioner.

(IV) The commissioner shall recognize United States jurisdictions that meet the requirement for accreditation under the national association of insurance commissioners financial standards and accreditation program as qualified jurisdictions.

(V) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may suspend the reinsurer's certification indefinitely in lieu of revocation.

(e) The commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the commissioner pursuant to rule. The commissioner shall publish a list of all certified reinsurers and their ratings.

(f) (I) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection (6) at a level consistent with its rating, as specified in rules promulgated by the commissioner.

(II) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer must maintain security in a form acceptable to the commissioner and consistent with the provisions of section 10-3-703 or in a multibeneficiary trust in accordance with subsection (5) of this section, except as otherwise provided in this subsection (6).

(III) If a certified reinsurer maintains a trust to fully secure its obligations subject to subsection (5) of this section, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer must maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection (6) or comparable laws of other United States jurisdictions and for its obligations subject to subsection (5) of this section. It is a condition to the grant of certification in this subsection (6) that the certified reinsurer must have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

(IV) The minimum trusteed surplus requirements provided in subsection (5) of this section are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection (6); except that such trust must maintain a minimum trusteed surplus of ten million dollars.

(V) With respect to obligations incurred by a certified reinsurer under this subsection (6), if the security is insufficient, the commissioner shall order the certified reinsurer to provide sufficient security for the incurred obligations within thirty days. If a certified reinsurer does not provide sufficient security for its obligations incurred under this subsection (6) within thirty days after being ordered to do so by the commissioner, the commissioner may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(VI) (A) For purposes of this subsection (6), a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent of its obligations.

(B) As used in this subsection (6), the term "terminated" refers to revocation, suspension, voluntary surrender, and inactive status.

(C) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, the requirement of this subparagraph (VI) does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(g) If an applicant for certification has been certified as a reinsurer in a jurisdiction accredited by the national association of insurance commissioners, the commissioner has the

discretion to defer to that jurisdiction's certification, and may defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

(h) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection (6), and the commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(6.5) (a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the following conditions:

(I) The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction.

(II) The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount set forth in commissioner rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction and a central fund containing a balance in amounts set forth in commissioner rule.

(III) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, that is set forth in commissioner rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and must also be licensed.

(IV) The assuming insurer must agree and provide adequate assurance to the commissioner, in a form specified by the commissioner in rule, as follows:

(A) The assuming insurer must provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in subsection (6.5)(a)(II) or (6.5)(a)(III) of this section or if any regulatory action is taken against it for serious noncompliance with applicable law;

(B) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. Nothing in this subsection (6.5)(a)(IV)(B) limits or in any way alters the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent that the agreements are unenforceable under applicable insolvency or delinquency law.

(C) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, that have been obtained by a ceding insurer or its legal successor and that have been declared enforceable in the jurisdiction where the judgment was obtained; and

(D) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of either a final judgment that is enforceable under the law of the jurisdiction

in which it was obtained or of a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate.

(V) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement that involves this state's ceding insurers or, if the assuming insurer enters into such a solvent scheme of arrangement, agree to notify the ceding insurer and the commissioner of the arrangement and agree to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities to the ceding insurer. The security must be in a form consistent with subsection (6) of this section and section 10-3-703 and as specified by the commissioner in rule.

(VI) The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, certain documentation to the commissioner, as specified by the commissioner in rule.

(VII) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in commissioner rule.

(VIII) The assuming insurer's supervisory authority must confirm to the commissioner on an annual basis that, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, the assuming insurer complies with the requirements set forth in subsections (6.5)(a)(II) and (6.5)(a)(III) of this section.

(b) (I) The commissioner shall timely create and publish a list of reciprocal jurisdictions.

(II) A list of reciprocal jurisdictions is published through the NAIC committee process. The commissioner's list must include any reciprocal jurisdiction as described in subsection (6.5)(h)(III)(A) or (6.5)(h)(III)(B) of this section and must consider any other reciprocal jurisdiction included on the NAIC list of reciprocal jurisdictions. The commissioner may approve a jurisdiction that does not appear on the NAIC list in accordance with criteria to be developed under rules issued by the commissioner.

(III) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction in accordance with a process set forth in rules issued by the commissioner; except that the commissioner shall not remove from the list a reciprocal jurisdiction as described in subsection (6.5)(h)(III)(A) or (6.5)(h)(III)(B) of this section. Upon removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to this part 7.

(c) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection (6.5) and to which cessions shall be granted credit in accordance with this subsection (6.5). The commissioner may add an assuming insurer to the list if an NAIC-accredited jurisdiction has added the assuming insurer to a list of assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under subsection (6.5)(a)(IV) of this section and complies with any additional requirement that the commissioner may impose in rule, except to the extent that the requirement conflicts with an applicable covered agreement.

(d) (I) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this subsection (6.5), the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection (6.5) in accordance with procedures set forth in rule.

(II) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit, except to the extent that the assuming insurer's obligations under the contract are secured in accordance with section 10-3-703.

(III) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with section 10-3-703.

(e) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer or its representative may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(f) Nothing in this subsection (6.5):

(I) Precludes an assuming insurer from providing the commissioner with information on a voluntary basis; or

(II) Limits or in any way alters the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this part 7 or other applicable law or rule.

(g) (I) Credit may be taken under this subsection (6.5) only for reinsurance agreements entered into, amended, or renewed on or after September 7, 2021, and only with respect to losses incurred and reserves reported on or after the later of:

(A) The date on which the assuming insurer has met all eligibility requirements pursuant to subsections (6.5)(a) and (6.5)(b) of this section; and

(B) The effective date of the new reinsurance agreement, amendment, or renewal.

(II) This subsection (6.5)(g) does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this subsection (6.5), as long as the reinsurance qualifies for credit under any other applicable provision of this part 7.

(III) Nothing in this subsection (6.5)(g):

(A) Authorizes an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement, except as permitted by the terms of the agreement; or

(B) Limits or in any way alters the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(h) As used in this subsection (6.5):

(I) "Covered agreement" means an agreement entered into pursuant to the federal "Dodd-Frank Wall Street Reform and Consumer Protection Act", as amended, 31 U.S.C. secs. 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

(II) "NAIC" means the National Association of Insurance Commissioners or any analogous successor organization.

(III) "Reciprocal jurisdiction" means a jurisdiction that meets one of the following conditions:

(A) A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union;

(B) A United States jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(C) A qualified jurisdiction, as determined by the commissioner pursuant to subsection (6)(d) of this section, that is not otherwise described in subsection (6.5)(h)(III)(A) or (6.5)(h)(III)(B) of this section and that meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in rule.

(7) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (2), (3), (4), (5), (6), or (6.5) of this section, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) (a) If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this state, the credit permitted by subsections (4) and (5) of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(I) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(II) To designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(b) This subsection (8) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

(9) If the assuming insurer does not meet the requirements of subsection (2), (3), or (4) of this section, the credit permitted by subsection (5) or (6) of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph (c) of subsection (5) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(b) The assets shall be distributed by, and claims must be filed with and valued by, the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(c) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part of the assets are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the commissioner with regulatory oversight of the trustee shall return the assets or part of the assets for distribution in accordance with the trust agreement.

(d) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection (9).

(10) (a) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

(b) The commissioner shall give the reinsurer notice and opportunity for hearing. The suspension or revocation must not take effect until after the commissioner's order on hearing, unless:

(I) The reinsurer waives its right to hearing;

(II) The commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under paragraph (g) of subsection (6) of this section; or

(III) The commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(c) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with section 10-3-703. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance shall be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with paragraph (f) of subsection (6) of this section or section 10-3-703.

(11) **Concentration risk.** (a) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the commissioner within thirty days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds fifty percent of the domestic ceding insurer's last reported surplus to policyholders or after it has determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed fifty percent of the domestic ceding insurer's last reported surplus to policyholders. The notification must demonstrate that the exposure is safely managed by the domestic ceding insurer.

(b) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner within thirty days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent of the ceding insurer's gross written premium in the prior calendar year or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed twenty percent of the ceding insurer's gross written premium in the prior calendar year. The notification must demonstrate that the exposure is safely managed by the domestic ceding insurer.

Source: L. 2014: Entire part R&RE, (HB 14-1315), ch. 295, p. 1202, § 1, effective January 1, 2015. **L. 2021:** (1) and (7) amended and (6.5) added, (HB 21-1063), ch. 40, p. 151, § 1, effective September 7.

Editor's note: In 2014, the provisions of subsection (8) were relettered to conform to statutory format.

10-3-703. Asset or reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of section 10-3-702. (1) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of section 10-3-702 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations under the reinsurance contract if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution, as defined in section 10-3-704 (2). This security may be in the form of:

(a) Cash;

(b) Securities listed by the securities valuation office of the national association of insurance commissioners, including those deemed exempt from filing as defined by the purposes and procedures manual of the securities valuation office, and qualifying as admitted assets;

(c) (I) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in section 10-3-704 (1), effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement;

(II) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; or

(d) Any other form of security acceptable to the commissioner.

Source: L. 2014: Entire part R&RE, (HB 14-1315), ch. 295, p. 1211, § 1, effective January 1, 2015.

10-3-704. Qualified United States financial institutions. (1) For purposes of section 10-3-703 (1)(c), a "qualified United States financial institution" means an institution that:

(a) Is organized or, in the case of a United States office of a foreign banking organization, licensed, under the laws of the United States or any state of the United States;

(b) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(c) Has been determined by either the commissioner or the securities valuation office of the national association of insurance commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(2) A "qualified United States financial institution" means, for purposes of those provisions of this part 7 specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(a) Is organized, or, in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state of the United States and has been granted authority to operate with fiduciary powers; and

(b) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

Source: L. 2014: Entire part R&RE, (HB 14-1315), ch. 295, p. 1212, § 1, effective January 1, 2015.

10-3-705. Rules - definitions. (1) The commissioner may adopt rules implementing this part 7.

(2) (a) The commissioner may adopt rules applicable to reinsurance arrangements described in this subsection (2)(a). Rules adopted pursuant to this subsection (2) must apply only to reinsurance relating to:

(I) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(II) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(III) Variable annuities with guaranteed death or living benefits;

(IV) Long-term care insurance policies; or

(V) Other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(b) A rule adopted pursuant to subsection (2)(a)(I) or (2)(a)(II) of this section must apply to any treaty containing:

(I) Policies issued on or after January 1, 2015; or

(II) Policies issued prior to January 1, 2015, if risk pertaining to pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

(c) A rule adopted pursuant this subsection (2) may require the ceding insurer, in calculating the amounts or forms of security required to be held under rules promulgated under this subsection (2), to use the valuation manual adopted by the NAIC under the NAIC standard valuation law, including all amendments adopted by the NAIC and in effect on the date on which the calculation is made, to the extent applicable.

(d) A rule adopted pursuant to this subsection (2) does not apply to cessions to an assuming insurer that:

(I) (A) Meets the conditions set forth in section 10-3-702 (6.5);

(B) Is certified in this state; or

(C) Maintains at least two hundred fifty million dollars in capital and surplus when calculated in accordance with the most recent NAIC accounting practices and procedures manual, as amended by the NAIC, excluding the impact of any permitted or prescribed practices; and

(II) Is licensed:

(A) In at least twenty-six states; or

(B) In at least ten states and licensed or accredited in a total of at least thirty-five states.

(e) The authority to adopt rules pursuant to this subsection (2) does not limit the commissioner's general authority to adopt rules pursuant to subsection (1) of this section.

(f) As used in this subsection (2), "NAIC" means the National Association of Insurance Commissioners.

Source: L. 2014: Entire part R&RE, (HB 14-1315), ch. 295, p. 1212, § 1, effective January 1, 2015. **L. 2024:** Entire section amended, (HB 24-1321), ch. 252, p. 1670, § 5, effective January 1, 2025.

10-3-706. Reinsurance agreements affected. This part 7 applies to all cessions after January 1, 2015, under reinsurance agreements that have an inception, anniversary, or renewal date not less than six months after January 1, 2015.

Source: L. 2014: Entire part R&RE, (HB 14-1315), ch. 295, p. 1212, § 1, effective January 1, 2015.

PART 8

INSURANCE HOLDING COMPANY SYSTEMS

Editor's note: This part 8 was numbered as article 33 of chapter 72, C.R.S. 1963. It was repealed and reenacted in 2014, resulting in the addition, relocation, or elimination of sections as well as subject matter. For amendments to this part 8 prior to 2014, consult the 2013 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this part 8, see the comparative tables located in the back of the index.

Cross references: For the applicability of part 12 of article 4 of this title 10 (producer-controlled property and casualty insurers) on the provisions of this part 8, see § 10-4-1205.

10-3-801. Definitions. As used in this part 8, unless the context otherwise requires:

(1) An "affiliate" of, or person "affiliated" with, a specific person is a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, the person specified.

(2) "Commissioner" means the commissioner of insurance, the commissioner's deputies, or the division of insurance, as appropriate.

(3) "Control", including the terms "controlling", "controlled by", and "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent or more of the voting securities of any other person. A person may rebut this presumption by a showing made in the manner provided by section 10-3-804 (9) that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and

making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(4) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything that would cause the insurer's risk-based capital to fall into company action level as set forth in rules promulgated by the commissioner or would cause the insurer to be in hazardous financial condition as set forth in rules promulgated by the commissioner.

(4.3) "Group capital calculation instructions" means the group capital calculation instructions adopted and amended by the National Association of Insurance Commissioners.

(4.5) "Group-wide supervisor" means a regulatory official who is authorized to conduct and coordinate group-wide supervision activities and who is designated or acknowledged by the commissioner pursuant to section 10-3-807.5.

(5) "Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer.

(6) "Insurer" has the meaning set forth in section 10-3-502 (12); except that "insurer" includes fraternal benefit societies and health maintenance organizations and does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(6.5) "Internationally active insurance group" means an insurance holding company system that:

(a) Includes an insurer registered pursuant to section 10-3-804;

(b) Writes insurance premiums in at least three countries;

(c) Writes insurance premiums in countries outside the United States, which insurance premiums account for at least ten percent of the insurance holding company system's total gross written premiums; and

(d) Has, based on an average of the immediately preceding three years, total assets of at least fifty billion dollars or total gross written premiums of at least ten billion dollars.

(7) "NAIC" or "National Association of Insurance Commissioners" means the organization of insurance regulators from the fifty states, the District of Columbia, and the five United States territories.

(7.5) "NAIC liquidity stress test framework" or "framework" means the NAIC publication that includes a history of the NAIC's development of regulatory liquidity stress testing, the scope criteria applicable for a specific data year, and the liquidity stress test instructions and reporting templates for a specific data year, as adopted by the NAIC, and as amended from time to time by the NAIC, in accordance with the procedures adopted by the NAIC.

(8) "Person" means an individual, corporation, limited liability company, partnership, association, joint stock company, trust, unincorporated organization, any similar entity, or any combination of the foregoing acting in concert but does not include a joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property.

(8.5) "Scope criteria" means the designated exposure bases, along with minimum magnitudes of exposure bases for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year.

(9) "Security holder" of a specified person means one who owns any security of the person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

(10) "Subsidiary" of a specified person means an affiliate controlled by the person, either directly or indirectly through one or more intermediaries.

(11) "Voting security" means a security convertible into or evidencing a right to acquire a voting security.

(12) "Wholly owned subsidiary" means a subsidiary owned by an insurer that owns shares of the issued and outstanding voting stock of the subsidiary having at least ninety-five percent of the total voting power of the stock for the election of directors.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1318, § 2, effective July 1. **L. 2019:** (4.5) and (6.5) added, (HB 19-1291), ch. 188, p. 2090, § 2, effective August 2. **L. 2023:** (7) amended, (HB 23-1301), ch. 303, p. 1816, § 7, effective August 7. **L. 2024:** (4.3), (7.5), and (8.5) added, (HB 24-1321), ch. 252, p. 1662, § 1, effective January 1, 2025.

Editor's note: This section is similar to former § 10-3-801 as it existed prior to 2014.

10-3-802. Subsidiaries of insurers. (1) A domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:

(a) Any kind of insurance business authorized by the jurisdiction in which it is incorporated;

(b) Acting as an insurance broker or insurance agent for its parent or for any of its parent's insurer subsidiaries;

(c) Investing, reinvesting, or trading in securities for its own account or that of its parent, a subsidiary of its parent, or an affiliate or subsidiary;

(d) Management of an investment company subject to or registered pursuant to the federal "Investment Company Act of 1940", 15 U.S.C. sec. 80a-1 et seq., as amended, including related sales and services;

(e) Acting as a broker-dealer subject to or registered pursuant to the federal "Securities Exchange Act of 1934", 15 U.S.C. sec. 78a et seq., as amended;

(f) Rendering investment advice to governments, government agencies, corporations, or other organizations or groups;

(g) Rendering other services related to the operations of an insurance business, such as actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal, and collection services;

(h) Ownership and management of assets that the parent corporation could itself own or manage;

(i) Acting as administrative agent for a governmental instrumentality that is performing an insurance function;

(j) Financing of insurance premiums, agents, and other forms of consumer financing;

(k) Any other business activity determined by the commissioner to be reasonably ancillary to an insurance business;

(l) Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section; and

(m) Any other kind of business that, in the opinion of the commissioner, would be in the best interest of the insurer and would not be detrimental to the policyholders or the public.

(2) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under other provisions of this title, a domestic insurer may also:

(a) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts that do not exceed the lesser of ten percent of the insurer's assets or fifty percent of the insurer's surplus as regards policyholders if, after such investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs. In calculating the amount of the investments, the commissioner shall exclude investments in domestic or foreign insurance subsidiaries and shall include:

(I) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities;

(II) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities; and

(III) All contributions to the capital or surplus of a subsidiary after its acquisition or formation.

(b) Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer if each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in paragraph (a) of this subsection (2) or in sections 10-3-213 to 10-3-242 applicable to the insurer. For the purpose of this paragraph (b), "the total investment of the insurer" includes:

(I) Any direct investment by the insurer in an asset; and

(II) The insurer's proportionate share of any investment in an asset by a subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary; and

(c) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries if, after the investment, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(3) Investments in common stock, preferred stock, debt obligations, or other securities of subsidiaries made in accordance with subsection (2) of this section are admitted assets of a domestic insurer, and such investments are not subject to any of the otherwise-applicable restrictions or limitations applicable to the investments of insurers.

(4) Any provision of this title to the contrary notwithstanding, any investment by a domestic insurer in the common stock, preferred stock, debt obligations, or other securities of

one or more insurance companies that are wholly owned subsidiaries of the domestic insurer are admitted assets of the domestic insurer, subject to the following provisions:

(a) If the authorized lines of business of the investing company and any such wholly owned subsidiary corporation together do not constitute the lines of business of a multiple-line company, the common stock, preferred stock, debt obligations, and other securities of the subsidiary corporation are not at any time an admitted asset of the investing company unless at such time the two companies have, without taking the common stock, preferred stock, debt obligations, and other securities into account as an asset of the investing company, a combined capital or guaranty fund and a combined surplus that are at least equal, respectively, to the sum of the minimum capital or minimum guaranty fund required by law for the authorized line of business of each of the two companies and the sum of the minimum surplus required by law for the authorized line of business of each of the two companies; except that this paragraph (a) does not apply to an investing company that is a fraternal benefit society.

(b) If the authorized lines of business of the investing company and any such wholly owned subsidiary corporation together constitute the lines of business of a multiple-line company, the common stock, preferred stock, debt obligations, and other securities of the wholly owned subsidiary corporation are not at any time an admitted asset of the investing company unless at such time the two companies have, without taking the stock into account as an asset of the investing company, a combined capital or guaranty fund and a combined surplus that are at least equal, respectively, to the minimum capital or guaranty fund and the minimum surplus required by law for the multiple-line company.

(c) If the authorized lines of business of any two insurance companies that are members of a chain of corporations directly or indirectly owned by a common parent corporation together constitute the lines of business of a multiple-line company, the common stock, preferred stock, debt obligations, and other securities of either of the two insurance companies are at any time an admitted asset of any insurance company, including the common parent corporation, that is a member of such chain of corporations, unless at such time the two insurance companies have a combined capital or guaranty fund and a combined surplus that are at least equal, respectively, to the minimum capital or guaranty fund and the minimum surplus required by law for such a multiple-line company.

(5) Whether any investment made pursuant to subsection (2) of this section meets the applicable requirements of that subsection (2) is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then-outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

(6) If an insurer ceases to control a subsidiary, it shall dispose of any investment made in the subsidiary pursuant to this section within three years after the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment has been made, the investment meets the requirements for investment under any other section of this title and the insurer has so notified the commissioner.

(7) Nothing in this part 8 prohibits a domestic insurer that, with the prior approval of the commissioner, organized or acquired a subsidiary from continuing to hold the insurer's investments in the subsidiary or from making further investments in the subsidiary consistent

with subsection (2) of this section, if the subsidiary engages only in the kind of business that was represented to the commissioner as a basis for such approval.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1320, § 2, effective July 1.

Editor's note: This section is similar to former § 10-3-802 as it existed prior to 2014.

10-3-803. Acquisition of control of or merger with domestic insurer - definitions. (1) (a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation of the exchange or acquisition, the person would, directly, indirectly, by conversion, or by exercise of any right to acquire, be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer, request, or invitation is made or the agreement is entered into, or before the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the insurer a statement containing the information required by this section and the commissioner has approved the offer, request, invitation, agreement, or acquisition in the manner prescribed in this part 8.

(b) In addition, if the person acting pursuant to this subsection (1) is:

(I) An individual, the person shall submit a set of fingerprints to the commissioner pursuant to subsection (3) of this section;

(II) A corporation, each executive officer and director of the corporation shall submit a set of fingerprints to the commissioner pursuant to subsection (3) of this section.

(c) For purposes of this section:

(I) "Domestic insurer" includes any person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance.

(II) "Person" does not include any securities broker holding, in the usual and customary broker's function, less than twenty percent of the voting securities of an insurance company or of any person that controls an insurance company.

(d) A controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least thirty days before the cessation of control. The commissioner shall determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information must remain confidential until the conclusion of the transaction unless the commissioner, in his or her discretion, determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in paragraph (a) of this subsection (1) has been filed, this paragraph (d) does not apply.

(e) With respect to a transaction subject to this section, the acquiring person shall also file a preacquisition notification with the commissioner, which must contain the information set forth in section 10-3-803.5 (3)(a). A failure to file the notification subjects the person to penalties specified in section 10-3-803.5 (5)(c).

(2) The statement filed pursuant to paragraph (a) of subsection (1) of this section shall be made under oath or affirmation and must contain the following:

(a) (I) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (1) of this section is to be effected, referred to in this section as the acquiring party;

(II) If the person is an individual, his or her principal occupation, all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years;

(III) If the person is not an individual, a report of the nature of its business operations during the past five years or for the lesser period as the person and any predecessors have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person or who perform or will perform functions appropriate to such positions. The list must include for each individual the information required by subparagraph (II) of this paragraph (a).

(b) The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing consideration; except that, where a source of consideration is a loan made in the lender's ordinary course of business, the identity of the lender must remain confidential if the person filing such statement so requests;

(c) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each acquiring party, or for the lesser period as the acquiring party and any predecessors have been in existence, and similar unaudited information as of a date not earlier than ninety days before the filing of the statement;

(d) Any plans or proposals that each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(e) The number of shares of any security referred to in subsection (1) of this section that each acquiring party proposes to acquire; the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection (1) of this section; and a statement as to the method by which the fairness of the proposal was arrived at;

(f) The amount of each class of any security referred to in subsection (1) of this section that is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) A full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection (1) of this section in which any acquiring party is involved, including the transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description must identify the persons with whom the contracts, arrangements, or understandings have been entered into.

(h) A description of the purchase of any security referred to in subsection (1) of this section during the twelve calendar months preceding the filing of the statement by any acquiring

party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid;

(i) A description of any recommendations to purchase any security referred to in subsection (1) of this section made during the twelve calendar months preceding the filing of the statement by any acquiring party, or by anyone based upon interviews or at the suggestion of the acquiring party;

(j) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (1) of this section, and, if distributed, of additional soliciting material relating to them;

(k) The term of any agreement, contract, or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (1) of this section for tender, and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard to the solicitation;

(l) An agreement by the person required to file the statement referred to in subsection (1) of this section that the person will provide the annual report, specified in section 10-3-804 (12), for so long as control exists;

(m) An acknowledgment by the person required to file the statement referred to in subsection (1) of this section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

(n) Such additional information as the commissioner may by rule prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

(3) (a) Each person described in subsection (1)(b) of this section shall submit a set of fingerprints to the commissioner at the time of filing the statement described in subsection (1)(a) of this section. The commissioner shall forward the fingerprints to the Colorado bureau of investigation for the purpose of conducting a state and national fingerprint-based criminal history record check utilizing records of the Colorado bureau of investigation and the federal bureau of investigation. The employer bears only the actual costs of the record check.

(b) When the results of a fingerprint-based criminal history record check of a person performed pursuant to this subsection (3) reveal a record of arrest without a disposition, the commissioner shall require that person to submit to a name-based judicial record check, as defined in section 22-2-119.3 (6)(d).

(4) If the person required to file the statement referred to in subsection (1) of this section is a partnership, limited partnership, syndicate, or other group, the commissioner may require the person to give the information called for by paragraphs (a) to (n) of subsection (2) of this section with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member, or person is a corporation or the person required to file the statement referred to in subsection (1) of this section is a corporation, the commissioner may require the corporation to give the information called for by paragraphs (a) to (n) of subsection (2) of this section with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of the corporation. If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the

change, shall be filed with the commissioner and sent to the insurer within two business days after the person learns of the change.

(5) If any offer, request, invitation, agreement, or acquisition referred to in subsection (1) of this section is proposed to be made by means of a registration statement under the federal "Securities Act of 1933", 15 U.S.C. sec. 77a et seq., as amended, or in circumstances requiring the disclosure of similar information under the federal "Securities Exchange Act of 1934", 15 U.S.C. sec. 78a et seq., as amended, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (1) of this section may utilize such documents in furnishing the information called for by that statement.

(6) (a) The commissioner shall conduct an independent investigation to determine the impact of a proposed merger on competition:

(I) When the proposed merger involves a transaction that the commissioner determines, under section 10-3-803.5 (4)(b), would present prima facie evidence of a violation of the competitive standard; and

(II) If the merger or acquisition involves a domestic entity authorized under article 16 of this title or referenced in section 6-18-302 (1)(b)(IV), C.R.S., or a domestic insurer authorized under section 10-3-102 that writes more than fifty percent of its business as health insurance coverage.

(b) The investigation must include an analysis of the probable effects of the merger on consumers and on suppliers of services. The commissioner shall not rely solely on representations of insurers to determine whether the merger will produce economies of scale or economies in resource utilization that cannot be achieved feasibly in any other way. The investigation must also include reviewing the market conduct examination and financial examination reports for this state or any other state, consumer complaint information from records maintained by the division or any other state regulatory agency, and any information from any state or federal agency related to the applicant. The investigation must commence no later than fifteen days after the applicant files the notification referred to in paragraph (e) of subsection (1) of this section.

(c) The commissioner shall make public the report of the independent investigation conducted pursuant to this subsection (6) no later than five business days after the submission of the report to the commissioner, subject to the "Colorado Open Records Act", part 2 of article 72 of title 24, C.R.S.

(d) The commissioner shall issue an executive summary, subject to the "Colorado Open Records Act", part 2 of article 72 of title 24, C.R.S., of the competitive impact analysis filed by the applicant to the transaction no later than fifteen business days after the analysis is filed with the division. The applicant shall file the competitive impact analysis at the same time the applicant files the notification referred to in paragraph (e) of subsection (1) of this section with the division.

(e) The commissioner shall make all data and reports pertaining to the proposed merger and collected or used by the commissioner in his or her investigation and analysis available to the public; except that, in the commissioner's discretion, the commissioner may redact specific items of proprietary information. If the insurer claims that information provided is proprietary, the insurer has the burden of proof on that issue.

(f) The commissioner shall complete the independent investigation pursuant to this subsection (6) no later than the day on which the application is deemed complete by the division.

The commissioner shall coordinate the completion of the independent investigation with the experts retained pursuant to paragraph (g) of subsection (8) of this section. The applicant shall bear any expenses associated with the independent investigation pursuant to subsection (8) of this section.

(7) The commissioner shall approve any merger or other acquisition of control referred to in subsection (1) of this section unless, after an independent investigation pursuant to subsection (6) of this section, and a public hearing on the acquisition, the commissioner finds that:

(a) After the change of control, the domestic insurer referred to in subsection (1) of this section would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly. In applying the competitive standard in this paragraph (b):

(I) The informational requirements of section 10-3-803.5 (3)(a) and the standards of section 10-3-803.5 (4)(b) apply;

(II) The commissioner shall not disapprove the merger or other acquisition if the commissioner finds that any of the situations meeting the criteria provided by section 10-3-803.5 (4)(c) exist; and

(III) The commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time.

(c) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders;

(d) The plans or proposals that the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or make any other material change in its business or corporate structure or management are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(e) The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(f) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(8) (a) The commissioner shall provide public notice of the filing of an application for a merger or acquisition no later than five business days after the receipt of the initial application. The commissioner shall also provide a general statement to the public of the process and procedures concerning a merger or acquisition of a domestic insurer. The statement must be a clear and concise statement of how the public may participate in the review of a merger or acquisition transaction, including a public hearing or providing written comments to the commissioner.

(b) No later than fifteen business days after the initial application for a merger pursuant to this section, the commissioner and the applicant shall establish the elements of a public notice of the transaction. The commissioner shall publish the notice no later than seven days after the division deems the application to be complete.

(c) The commissioner shall hold the public hearing referred to in subsection (7) of this section within thirty days after the statement required by subsection (1) of this section is filed,

and the commissioner shall give at least twenty days' notice of the hearing to the person filing the statement. The commissioner shall give not less than seven days' notice of the public hearing pursuant to paragraph (b) of this subsection (8) to the insurer and to the public. The insurer shall give the notice to its security holders. The commissioner shall make a determination within thirty days after the conclusion of the hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interests may be affected have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and, in connection therewith, are entitled to conduct discovery proceedings in the same manner as is presently allowed in the district courts of this state. All discovery proceedings must be concluded no later than three days before the commencement of the public hearing.

(d) The deadline for submission of written public comment to respond to testimony from the applicant is ten business days after the hearing. The commissioner shall review all responses and provide a report summarizing all public testimony.

(e) If the proposed acquisition of control will require the approval of a state other than Colorado in addition to the approval of the commissioner, the public hearing referred to in subsection (7) of this section may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (1) of this section. The person shall file the statement referred to in subsection (1) of this section with the NAIC within five days after making the request for a public hearing. A commissioner may opt out of a consolidated hearing and shall provide notice to the applicant of the opt-out within ten days after the receipt of the statement referred to in subsection (1) of this section. A hearing conducted on a consolidated basis must be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. The commissioners shall hear and receive evidence. A commissioner may attend the hearing in person or by telecommunication.

(f) In connection with a change of control of a domestic insurer, the commissioner shall make any determination that the person acquiring control of the insurer is required to maintain or restore the capital of the insurer to the level required by the laws and rules of this state not later than sixty days after the date of notification of the change in control submitted pursuant to paragraph (a) of subsection (1) of this section.

(g) The commissioner may retain, at the acquiring person's expense, any attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

(9) The insurer shall mail a synopsis of the statement referred to in subsection (1) of this section, and all notices of public hearings held pursuant to subsection (7) of this section, to its shareholders within five business days after the insurer has received such statements, amendments, other material, or notices filed pursuant to this section. The person making the filing shall bear the expenses of the mailing. As security for the payment of such expenses, the person shall file with the commissioner an acceptable bond or other deposit in an amount to be determined by the commissioner.

(10) This section does not apply to:

(a) An exchange of stock of a domestic insurer actually accomplished in accordance with sections 10-3-604 to 10-3-606, or any preliminary agreement between a domestic insurer and

any other corporation entered into in contemplation of the adoption of a plan of exchange under part 6 of this article; or

(b) An offer, request, invitation, agreement, or acquisition that the commissioner, by order, exempts from this section as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not comprehended within the purposes of this section.

(11) The following are violations of this section:

(a) The failure to file any statement, amendment, or other material required to be filed pursuant to subsection (1) or (2) of this section; or

(b) The effectuation of, or any attempt to effectuate, an acquisition of control of, or merger with, a domestic insurer unless the commissioner has given his or her approval to the acquisition or merger.

(12) The courts of this state have jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the commissioner under this section and over all actions involving the person arising out of violations of this section, and each such person is deemed to have performed acts equivalent to and constituting an appointment by the person of the commissioner to be his or her true and lawful attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of a violation of this section. Copies of all such lawful process shall be served on the commissioner and the commissioner shall transmit the process by registered or certified mail to the person at his or her last-known address.

(13) If the procedures set forth in this section are not followed before the issuance of the order of the commissioner that approves or disapproves the merger, the aggrieved party may seek remedies pursuant to section 10-3-814.

(14) Nothing in this section limits the commissioner's ability to conduct a hearing for transactions that do not meet the requirements in subsection (6) of this section.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1323, § 2, effective July 1. **L. 2019:** (3) amended, (HB 19-1166), ch. 125, p. 538, § 3, effective April 18. **L. 2022:** (3)(b) amended, (HB 22-1270), ch. 114, p. 513, § 4, effective April 21.

Editor's note: This section is similar to former § 10-3-803 as it existed prior to 2014.

10-3-803.5. Acquisitions involving insurers not otherwise covered - definitions. (1) As used in this section, unless the context otherwise requires:

(a) "Acquisition" means an agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes the acquisition of voting securities, the acquisition of assets, bulk reinsurance, and mergers.

(b) For the purposes of subparagraph (IV) of paragraph (b) of subsection (2) of this section, "insurer" includes any company or group of companies under common management, ownership, or control.

(c) "Involved insurer" includes an insurer that either acquires or is acquired through an acquisition, is affiliated with an insurer that acquires or is acquired through an acquisition, or is the result of a merger.

(d) "Market" means:

(I) For the purposes of subparagraph (IV) of paragraph (b) of subsection (2) of this section, direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(II) For the purposes of paragraph (b) of subsection (4) of this section, the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state.

(2) **Scope.** (a) Except as exempted in paragraph (b) of this subsection (2), this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.

(b) This section does not apply to the following:

(I) A purchase of securities solely for investment purposes if the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under section 10-3-801 (3), the purchase is not solely for investment purposes unless the insurance commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state.

(II) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the commissioner in accordance with paragraph (b) of subsection (3) of this section thirty days before the proposed effective date of the acquisition; except that preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other subparagraph of this paragraph (b);

(III) The acquisition of already affiliated persons;

(IV) An acquisition if, as an immediate result of the acquisition:

(A) In no market would the combined market share of the involved insurers exceed five percent of the total market;

(B) There would be no increase in any market share; or

(C) In no market would the combined market share of the involved insurers exceed twelve percent of the total market and the combined market share increase by more than two percent of the total market;

(V) An acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business; or

(VI) An acquisition of an insurer whose domiciliary insurance commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternatives to improving its condition; the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the commissioner of this state.

(3) (a) An acquisition covered by subsection (2) of this section may be subject to an order pursuant to subsection (5) of this section unless the acquiring person files a preacquisition notification and the waiting period has expired. The acquired person may file a preacquisition notification. The commissioner shall give confidential treatment to information submitted under this subsection (3) in the same manner as otherwise provided in this part 8; except that the notice required by subsection (3)(d)(I) of this section must include the information specified in subsection (3)(d)(I) of this section if the preacquisition notification presents prima facie evidence of a violation of the competitive standard specified in subsection (4)(b) of this section.

(b) The preacquisition notification must be in the form and contain the information as prescribed by the NAIC relating to those markets which, under subparagraph (IV) of paragraph (b) of subsection (2) of this section, cause the acquisition not to be exempted from this section. The commissioner may require additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection (4) of this section. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of the economist indicating his or her ability to render an informed opinion.

(c) Except as otherwise provided in subsection (3)(d) of this section:

(I) The waiting period begins on the date of receipt by the commissioner of a preacquisition notification and ends on the earlier of the thirtieth day after the date of receipt or termination of the waiting period by the commissioner; and

(II) Before the end of the waiting period, the commissioner, on a one-time basis, may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period ends on the earlier of the thirtieth day after receipt of the additional information by the commissioner or termination of the waiting period by the commissioner.

(d) If the proposed acquisition involves one or more health insurers:

(I) The commissioner shall provide public notice of the filing of an application for an acquisition of control referred to in subsection (2)(a) of this section no later than five business days after the receipt of the preacquisition notification required by subsection (3)(a) of this section. If the preacquisition notification presents prima facie evidence of a violation of the competitive standard specified in subsection (4)(b) of this section, the notice must include:

(A) The relevant product for which prima facie evidence of the violation of the competitive standard was presented in the preacquisition notice;

(B) The relevant geographic market for which prima facie evidence of the violation of the competitive standard was presented in the preacquisition notice; and

(C) As specified in subsection (4)(b)(I)(A) or (4)(b)(I)(B) of this section, the shares of the market in which prima facie evidence of the violation of the competitive standard was presented in the preacquisition notice.

(II) The commissioner shall review the impact of a proposed acquisition on competition when the proposed acquisition involves a transaction that the commissioner determines would present prima facie evidence of a violation of the competitive standard specified in subsection (4) of this section. The review must include a public hearing or an opportunity for the public to submit written comments to the commissioner.

(III) The waiting period begins on the date of receipt by the commissioner of a preacquisition notification and, except as specified in subsection (3)(d)(IV) of this section, ends on the earlier of the thirtieth day after the date of receipt of the preacquisition notification or termination of the waiting period by the commissioner.

(IV) If the commissioner allows for public comment as part of the review of a merger, the waiting period ends on the earlier of the thirtieth day after the date of receipt of the preacquisition notification or termination of the waiting period by the commissioner. If the commissioner holds a hearing as part of the review of a merger, the waiting period ends on the date of the hearing.

(V) Before the end of the waiting period, the commissioner, on a one-time basis, may require the submission of additional needed information relevant to the proposed acquisition.

(VI) Nothing in this section prevents an applicant from making the preacquisition notification available for confidential stakeholder inspection.

(4) **Competitive standard.** (a) The commissioner may enter an order under paragraph (a) of subsection (5) of this section with respect to an acquisition if:

(I) There is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly; or

(II) The insurer fails to file adequate information in compliance with subsection (3) of this section.

(b) In determining whether a proposed acquisition would violate the competitive standard of paragraph (a) of this subsection (4), the commissioner shall consider the following:

(I) An acquisition covered under section 10-3-803 (2) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standards if one of the following occurs:

(A) The market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more

(B) The market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

(II) A highly concentrated market is one in which the share of the four largest insurers is seventy-five percent or more of the market. Percentages not shown in the tables of sub-subparagraphs (A) and (B) of subparagraph (I) of this paragraph (b) are interpolated proportionately to the percentages that are shown. For the purpose of subparagraph (I) of this paragraph (b), the insurer with the largest share of the market is deemed to be insurer A.

(III) Whether there is a significant trend toward increased concentration in the market. There is a significant trend toward increased concentration in the market when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven percent or more of the market over a period of time extending from any base year five to ten years prior to the acquisition up to the time of the acquisition. An acquisition covered under subsection (2) of this section involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (a) of this subsection (4) if:

(A) There is a significant trend toward increased concentration in the market;

(B) One of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share; and

(C) Another involved insurer's market is two percent or more; and

(IV) Even though an acquisition is not prima facie violative of the competitive standard under subparagraph (I) or (III) of this paragraph (b), the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under subparagraph (I) or (III) of this paragraph (b), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subparagraph (IV) include the following: Market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(c) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(d) The commissioner shall not enter an order under paragraph (a) of subsection (5) of this section if the acquisition will:

(I) Yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way and the public benefits that would arise from such economies exceed the public benefits that would arise from not lessening competition; or

(II) Substantially increase the availability of insurance and the public benefits of the increase exceed the public benefits that would arise from not lessening competition.

(5) **Orders and penalties.** (a) (I) If an acquisition violates the standards of this section, the commissioner may enter an order:

(A) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or

(B) Denying the application of an acquired or acquiring insurer for a license to do business in this state.

(II) The commissioner shall not enter an order under this paragraph (a) unless:

(A) There is a hearing on the proposed order;

(B) Except for a hearing held pursuant to subsection (3)(d) of this section, notice of the hearing is issued before the end of the waiting period and not less than fifteen days before the hearing;

(C) For a hearing held pursuant to subsection (3)(d) of this section, notice of the hearing is issued by the later of the thirtieth day after receipt by the commissioner of a preacquisition notification or by the date the commissioner sets for the receipt of public comments;

(D) Except for a hearing held pursuant to subsection (3)(d) of this section, the hearing is concluded and the order is issued no later than sixty days after the date of the filing of the preacquisition notification with the commissioner; and

(E) For a hearing held pursuant to subsection (3)(d) of this section, the hearing is concluded and the order is issued no later than sixty days after the end of the waiting period.

(III) Every order must be accompanied by a written decision of the commissioner setting forth findings of fact and conclusions of law.

(IV) An order entered pursuant to this paragraph (a) does not apply if the acquisition is not consummated.

(b) A person who violates a cease-and-desist order of the commissioner under paragraph (a) of this subsection (5) and while the order is in effect is, after notice and hearing and upon order of the commissioner, subject at the discretion of the commissioner to one or more of the following:

(I) A monetary penalty of not more than ten thousand dollars for every day of violation; or

(II) Suspension or revocation of the person's license.

(c) An insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good-faith effort to comply with any filing requirement, is subject to a fine of not more than fifty thousand dollars.

(6) Sections 10-3-810 (2) and (3) and 10-3-812 do not apply to acquisitions covered under subsection (2) of this section.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1332, § 2, effective July 1. **L. 2017:** (3)(a), (3)(c), and (5)(a)(II) amended and (3)(d) added, (SB 17-198), ch. 300, p. 1643, § 1, effective June 2.

Editor's note: This section is similar to former § 10-3-803.5 as it existed prior to 2014.

10-3-804. Registration of insurers - rules - group capital calculation - liquidity stress test - exemptions. (1) (a) Every insurer that is authorized to do business in this state and that is a member of an insurance holding company system shall register with the commissioner; except that registration is not required for a foreign insurer that is subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in:

(I) This section;

(II) Section 10-3-805 (1)(a), (2), or (3); and

(III) Either section 10-3-805 (1)(b) or a provision such as the following: "Each registered insurer must keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen days after the end of the month in which it learns of each change or addition."

(b) An insurer that is subject to registration under this section shall register within fifteen days after it becomes subject to registration, and annually thereafter by April 30 of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer authorized to do business in the state that is a member of an insurance holding company system

and that is not subject to registration under this section to furnish a copy of the registration statement, the summary specified in subsection (3) of this section, or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

(2) Every insurer subject to registration shall file the registration statement with the commissioner on a form and in a format prescribed by the NAIC, which must contain the following current information:

(a) The capital structure, general financial condition, and ownership and management of the insurer and any person controlling the insurer;

(b) The identity and relationship of every member of the insurance holding company system;

(c) The following agreements in force, and transactions currently outstanding or that have occurred during the last calendar year between the insurer and its affiliates:

(I) Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(II) Purchases, sales, or exchange of assets;

(III) Transactions not in the ordinary course of business;

(IV) Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(V) All management agreements, service contracts, and cost-sharing arrangements;

(VI) Reinsurance agreements;

(VII) Dividends and other distributions to shareholders;

(VIII) Consolidated tax allocation agreements;

(IX) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, purchase assets of, or make investments in any affiliate of the insurer making such loans or extensions of credit; and

(X) Any material transactions, specified by rule, that the commissioner determines may adversely affect the interest of such insurer's policyholders;

(d) Information about each pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(e) If requested by the commissioner, financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include annual audited financial statements filed with the federal securities and exchange commission pursuant to the federal "Securities Act of 1933", 15 U.S.C. sec. 77a et seq., as amended, or the federal "Securities Exchange Act of 1934", 15 U.S.C. sec. 78a et seq., as amended. An insurer required to file financial statements pursuant to this paragraph (e) may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the securities and exchange commission.

(f) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner;

(g) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(h) Any other information required by the commissioner by rule.

(3) All registration statements must contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(4) No information need be disclosed on the registration statement filed pursuant to subsection (2) of this section if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans, extensions of credit, investments, or guarantees involving one-half of one percent or less of an insurer's admitted assets as of the thirty-first day of the preceding December are not material for purposes of this subsection (4).

(5) Subject to section 10-3-805 (2), each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen business days following the declaration of the dividends or distribution.

(6) A person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer where the information is reasonably necessary to enable the insurer to comply with this part 8.

(7) The commissioner shall terminate the registration of any insurer that demonstrates that it no longer is a member of an insurance holding company system.

(8) The commissioner may require or allow two or more affiliated insurers subject to registration to file a consolidated registration statement.

(9) The commissioner may allow an insurer that is authorized to do business in this state and that is part of an insurance holding company system to register on behalf of any affiliated insurer that is required to register under subsection (1) of this section and to file all information and material required to be filed under this section.

(10) This section does not apply to any insurer, information, or transaction if and to the extent that the commissioner by rule or order exempts it from this section.

(11) A person, including an insurer or any member of an insurance holding company system, may file with the commissioner a disclaimer of affiliation with any authorized insurer. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which the commissioner shall grant. The disclaiming party need not register under this section if approval of the disclaimer has been granted by the commissioner or if the disclaimer is deemed to have been approved.

(12) (a) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report must, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The controlling person shall file the report with the lead state commissioner of the insurance holding company system as determined by the procedures within the financial analysis handbook adopted by the NAIC.

(b) Except as provided in subsections (12)(b)(I) to (12)(b)(IV) and (12)(c) to (12)(e) of this section, the ultimate controlling person of each insurer subject to registration shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner. The report must be completed in accordance with the NAIC group capital calculation instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report must be filed with the lead state commissioner of the insurance holding company system as directed by the lead state commissioner in accordance with the procedures within the financial analysis handbook adopted by the NAIC. The following insurance holding company systems are exempt from filing the group capital calculation:

(I) An insurance holding company system that has only one insurer within its holding company structure, that only writes business, and that is only licensed in its domestic state and assumes no business from any other insurer;

(II) An insurance holding company system that is required to perform a group capital calculation specified by the United States federal reserve board. The lead state commissioner shall request the calculation from the federal reserve board under the terms of information-sharing agreements in effect. If the federal reserve board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the group capital calculation filing.

(III) An insurance holding company system whose non-United States group-wide supervisor is located within a reciprocal jurisdiction as described in section 10-3-702 that recognizes the United States' state regulatory approach to group supervision and group capital;

(IV) An insurance holding company system:

(A) That provides information to the lead state commissioner that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the lead state commissioner to comply with the NAIC group supervision approach, as detailed in the NAIC financial analysis handbook; and

(B) Whose non-United States group-wide supervisor that is not in a reciprocal jurisdiction recognizes and accepts, as specified by the lead state commissioner in regulation, the group capital calculation as the worldwide group capital assessment for United States insurance groups that operate in that jurisdiction.

(c) Notwithstanding subsections (12)(b)(III) and (12)(b)(IV) of this section and this subsection (12)(c), the lead state commissioner shall require the group capital calculation for United States operations of any non-United-States-based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

(d) Notwithstanding the exemptions from filing the group capital calculation stated in subsections (12)(b)(I) to (12)(b)(IV) of this section, the lead state commissioner may exempt the ultimate controlling person from filing the annual group capital calculation or accept a limited group capital filing or report in accordance with criteria as specified by the regulations promulgated by the lead state commissioner.

(e) If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital

calculation under this section, the insurance holding company system must file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

(f) (I) The ultimate controlling person of an insurer subject to registration and also scoped into the NAIC liquidity stress test framework shall file the results of a specific year's liquidity stress test. The filing must be made to the lead state commissioner of the insurance holding company system as determined by the procedures within the financial analysis handbook adopted by the NAIC.

(II) (A) The NAIC liquidity stress test framework includes scope criteria applicable to a specific data year. At least annually, the NAIC financial stability task force or its successor shall review the scope criteria. Any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured takes effect on January 1 of the year following the calendar year when such changes are adopted. Insurers meeting at least one threshold of the scope criteria are considered scoped into the NAIC liquidity stress test framework for the specified data year unless the lead state commissioner, in consultation with the NAIC financial stability task force or its successor, determines the insurer should not be scoped into the NAIC liquidity stress test framework for that data year. Similarly, insurers that do not trigger at least one threshold of the scope criteria are considered scoped out of the NAIC liquidity stress test framework for the specified data year, unless the lead state commissioner, in consultation with the NAIC financial stability task force or its successor, determines the insurer should be scoped into the framework for that data year.

(B) As part of the determination for an insurer, the lead state commissioner, in consultation with the NAIC financial stability task force or its successor, shall assess a regulator's desire to avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis.

(III) The performance of, and filing of the results from, a specific year's liquidity stress test must comply with the NAIC liquidity stress test framework's instructions and reporting templates for that year and any lead state commissioner determinations, in conjunction with the NAIC financial stability task force or its successor, provided within the framework.

(13) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for filing is a violation of this section.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1338, § 2, effective July 1. **L. 2024:** (12) amended, (HB 24-1321), ch. 252, p. 1662, § 2, effective January 1, 2025.

Editor's note: This section is similar to former § 10-3-804 as it existed prior to 2014.

10-3-805. Standards and management of an insurer within an insurance holding company system - rules. (1) **Transactions within an insurance holding company system.** (a) Transactions within an insurance holding company system to which an insurer subject to registration is a party are subject to the following standards:

(I) The terms must be fair and reasonable;

(II) Agreements for cost-sharing services and management must include such provisions as required by rules issued by the commissioner;

(III) Charges or fees for services performed must be reasonable;

(IV) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(V) The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties;

(VI) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates must be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs;

(VII) (A) If an insurer subject to this article 3 is deemed by the commissioner to be in a hazardous financial condition, as defined by rule of the commissioner, or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, then the commissioner may require the insurer to secure and maintain either a deposit, held by the commissioner, or a bond, as determined by the insurer at the insurer's discretion, for the protection of the insurer for the duration of the contract or agreement or the existence of the condition for which the commissioner required the deposit or the bond.

(B) In determining whether a deposit or a bond is required, the commissioner shall consider whether concerns exist with respect to the affiliated person's ability to fulfill a contract or agreement if the insurer were to be put into liquidation. Once the insurer is deemed to be in a hazardous financial condition or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, and a deposit or bond is necessary, the commissioner may determine the amount of the deposit or bond, not to exceed the value of a contract or agreement in any one year, and whether such deposit or bond should be required for a single contract, multiple contracts, or a contract only with a specific person.

(VIII) The records and data of the insurer held by an affiliate are and remain the property of the insurer and are subject to control of the insurer. The affiliate shall ensure that the records and data are identifiable and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons' records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records, or similar records within the possession, custody, or control of the affiliate. At the request of the insurer, the affiliate shall permit the receiver to obtain a complete set of all records of any type that pertain to the insurer's business, obtain access to the operating systems on which the data is maintained, obtain the software that runs the operating systems either through assumption of licensing agreements or otherwise, and restrict the use of the data by the affiliate if the receiver or the affiliate is not operating the insurer's business. The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate's default under a lease or other agreement.

(IX) A premium or other money belonging to the insurer that is collected by or held by an affiliate is the exclusive property of the insurer and is subject to the control of the insurer. Any right of offset in the event an insurer is placed into receivership is subject to part 5 of this article 3.

(b) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, that are subject to any materiality standards contained in subparagraphs (I) to (VII) of this paragraph (b), shall not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty days before entering into the transaction, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period:

(I) Sales, purchases, exchanges, loans, extensions of credit, or investments, if the transactions are equal to or exceed:

(A) With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders as of the thirty-first day of the preceding December; or

(B) With respect to life insurers, three percent of the insurer's admitted assets as of the thirty-first day of the preceding December;

(II) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, purchase assets of, or make investments in, any affiliate of the insurer making the loans or extensions of credit if the transactions are equal to or exceed:

(A) With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders as of the thirty-first day of the preceding December; or

(B) With respect to life insurers, three percent of the insurer's admitted assets as of the thirty-first day of the preceding December;

(III) Reinsurance agreements or modifications, including:

(A) All reinsurance pooling agreements; and

(B) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five percent of the insurer's surplus as regards policyholders, as of the thirty-first day of the preceding December, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(IV) All management agreements, service contracts, tax allocation agreements, guarantees, and cost-sharing arrangements;

(V) Guarantees when made by a domestic insurer; except that a guarantee that is quantifiable as to amount is not subject to the notice requirements of this subparagraph (V) unless it exceeds the lesser of one-half of one percent of the insurer's admitted assets or ten percent of surplus as regards policyholders as of the thirty-first day of the preceding December. Guarantees that are not quantifiable as to amount are subject to the notice requirements of this subparagraph (V).

(VI) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in such investments, exceeds two and one-half percent of the insurer's surplus to policyholders; except that direct or indirect acquisitions or investments in subsidiaries acquired pursuant to section 10-

3-802 or authorized under any other section of Colorado law, or in nonsubsidiary insurance affiliates that are subject to this part 8, are exempt from this requirement; and

(VII) Any material transactions, specified by rule, that the commissioner determines may adversely affect the interests of the insurer's policyholders.

(c) The notice for amendments or modifications specified in paragraph (b) of this subsection (1) must include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.

(d) Nothing in paragraph (b) of this subsection (1) authorizes or permits any transactions that, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(e) A domestic insurer shall not enter into transactions that are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his or her authority under section 10-3-811.

(f) The commissioner, in reviewing transactions pursuant to paragraph (b) of this subsection (1), shall consider whether the transactions comply with the standards set forth in paragraph (a) of this subsection (1) and whether they may adversely affect the interests of policyholders.

(g) A domestic insurer shall notify the commissioner within thirty days after any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent of the corporation's voting securities.

(h) (I) An affiliate that is party to an agreement or contract with a domestic insurer that is subject to subsection (1)(b)(IV) of this section is subject to the jurisdiction of any supervision, seizure, conservatorship, or receivership proceedings against the insurer and to the authority of any supervisor, conservator, rehabilitator, or liquidator for the insurer appointed pursuant to supervision and receivership acts for the purpose of interpreting, enforcing, and overseeing the affiliate's obligations under the agreement or contract to perform services for the insurer that:

(A) Are an integral part of the insurer's operations, including management, administration, accounting, data processing, marketing, underwriting, claims handling, investment, or any other similar functions; or

(B) Are essential to the insurer's ability to fulfill its obligations under its insurance policies.

(II) The commissioner may require that an agreement or contract pursuant to subsection (1)(b)(IV) of this section for the provision of services described in subsection (1)(h)(I) of this section specifies that the affiliate consents to the jurisdiction as set forth in this subsection (1)(h).

(2) **Dividends and other distributions.** (a) A domestic insurer shall not pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty days after the commissioner has received notice of the declaration of the dividend or distribution and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.

(b) For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property whose fair market value, together with that of other dividends or distributions made within the preceding twelve months, exceeds the lesser of:

(I) Ten percent of the insurer's surplus as regards policyholders as of the thirty-first day of the preceding December; or

(II) The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the thirty-first day of the preceding December, but not including pro rata distributions of any class of the insurer's own securities.

(c) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediately preceding calendar years.

(d) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the commissioner's approval, and the declaration confers no rights upon shareholders until:

(I) The commissioner has approved the payment of the dividend or distribution; or

(II) The commissioner has not disapproved payment within the thirty-day period referred to in paragraph (a) of this subsection (2).

(3) For purposes of this part 8, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the commissioner shall consider the following factors, among others:

(a) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(b) The extent to which the insurer's business is diversified among several lines of insurance;

(c) The number and size of risks insured in each line of business;

(d) The extent of the geographical dispersion of the insurer's insured risks;

(e) The nature and extent of the insurer's reinsurance program;

(f) The quality, diversification, and liquidity of the insurer's investment portfolio;

(g) The recent past and projected future trend in the size of the insurer's investment portfolio;

(h) The surplus as regards policyholders maintained by other comparable insurers;

(i) The adequacy of the insurer's reserves;

(j) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.

(k) The quality of the insurer's earnings and the extent to which the reported earnings include extraordinary items, such as surplus relief reinsurance transactions; and

(l) Any other situation not described in this subsection (3) that may render the operations of the insurer hazardous to the public or its policyholders.

(4) The commissioner may promulgate rules to implement this section.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1342, § 2, effective July 1. **L. 2024:** (1)(a)(V) amended and (1)(a)(VII) to (1)(a)(IX), (1)(h), and (4) added, (HB 24-1321), ch. 252, p. 1665, § 3, effective January 1, 2025.

Editor's note: This section is similar to former § 10-3-805 as it existed prior to 2014.

10-3-806. Examination. (1) Subject to the limitation contained in this section and in addition to the powers that the commissioner has under this title relating to the examination of insurers, the commissioner may examine any insurer registered under section 10-3-804 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(2) **Access to books and records.** (a) The commissioner may order any insurer registered under section 10-3-804 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this section.

(b) To determine compliance with this section, the commissioner may order any insurer registered under section 10-3-804 to produce information not in the possession of the insurer if the insurer can obtain access to the information pursuant to contractual relationships, statutory obligations, or other methods. If the insurer cannot obtain the information requested by the commissioner, the insurer shall provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of the information.

(3) The commissioner may retain, at the registered insurer's expense, such attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as are reasonably necessary to assist in the conduct of the examination under subsection (1) of this section. Each person so retained is under the direction and control of the commissioner and shall act in a purely advisory capacity.

(4) Each registered insurer producing for examination records, books, and papers pursuant to subsection (1) of this section is liable for and shall pay the expense of examination in accordance with part 2 of article 1 of this title.

(5) If the insurer fails to comply with an order, the commissioner may examine the affiliates to obtain the information. The commissioner may also issue subpoenas, administer oaths, and examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court. Every person shall attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. Witnesses not employed by the insurer shall be paid the same fees and mileage as are paid to witnesses in the courts of this state, which fees, mileage, and actual expenses, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, must be itemized by the commissioner and charged against, and be paid by, the company being examined.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1346, § 2, effective July 1. **L. 2016:** (5) added, (SB 16-029), ch. 32, p. 72, § 1, effective March 18.

Editor's note: This section is similar to former § 10-3-806 as it existed prior to 2014.

10-3-807. Supervisory colleges. (1) With respect to any insurer registered under section 10-3-804, and in accordance with subsection (3) of this section, the commissioner may participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this section. The powers of the commissioner with respect to supervisory colleges include the following:

(a) Initiating the establishment of a supervisory college;

(b) Clarifying the membership and participation of other supervisors in the supervisory college;

(c) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(d) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(e) Establishing a crisis management plan.

(2) Each registered insurer subject to this section is liable for and shall pay the reasonable expenses of the commissioner's participation in a supervisory college in accordance with subsection (3) of this section, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of these expenses.

(3) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, and risk management and governance processes, and as part of the examination of individual insurers in accordance with section 10-3-806, the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies. The commissioner may enter into agreements, in accordance with section 10-3-808 (3), providing the basis for cooperation between the commissioner and the other regulatory agencies and the activities of the supervisory college. Nothing in this section delegates to the supervisory college the commissioner's authority to regulate or supervise the insurer or its affiliates within his or her jurisdiction.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1347, § 2, effective July 1.

10-3-807.5. Group-wide supervision of internationally active insurance groups - information collection - cooperation - rules. (1) (a) The commissioner may act as the group-wide supervisor for any internationally active insurance group in accordance with this section. However, the commissioner, in cooperation with other state, federal, and international regulatory agencies, may designate or acknowledge another regulatory official as the group-wide supervisor for an internationally active insurance group that:

(I) Does not have substantial insurance operations in the United States;

(II) Has substantial insurance operations in the United States, but not in Colorado; or

(III) Has substantial insurance operations in the United States and in Colorado, but the commissioner has determined pursuant to the factors set forth in subsections (2) and (6) of this section that the other regulatory official is the appropriate group-wide supervisor.

(b) An insurance holding company system that does not qualify as an internationally active insurance group may request that the commissioner designate or acknowledge a group-wide supervisor pursuant to this section.

(2) (a) When designating or acknowledging a group-wide supervisor pursuant to subsection (1) of this section, the commissioner shall consider the following factors:

(I) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities;

(II) The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group;

(III) The location of the executive offices or the largest operational offices of the internationally active insurance group;

(IV) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:

(A) Substantially similar to the system of regulation provided under the laws of this state; or

(B) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(V) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

(b) The commissioner shall designate a regulatory official other than the commissioner to serve as the group-wide supervisor of an internationally active insurance group only:

(I) After consideration of the factors listed in subsection (2)(a) of this section;

(II) In cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group; and

(III) In consultation with the internationally active insurance group.

(3) Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, the commissioner shall make a new designation or acknowledgment as to the appropriate group-wide supervisor for the internationally active insurance group in the event of a material change that results in:

(a) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities; or

(b) This state being the place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group.

(4) Pursuant to section 10-3-806, the commissioner may collect from any insurer registered pursuant to section 10-3-804 all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision

by the commissioner, the commissioner shall notify the insurer and the ultimate controlling person within the internationally active insurance group of the pending determination. After receiving such notice, the internationally active insurance group has thirty days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the Colorado register and on the division's website the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

(5) If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner may engage in any of the following group-wide supervision activities:

(a) Assess the enterprise risks within the internationally active insurance group to ensure that:

(I) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(II) Reasonable and effective mitigation measures are in place;

(b) Request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including information about the members of the internationally active insurance group regarding:

(I) Governance, risk assessment, and management;

(II) Capital adequacy; and

(III) Material intercompany transactions;

(c) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of the internationally active insurance group that are engaged in the business of insurance;

(d) Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information, subject to the confidentiality provisions of section 10-3-808, whether through supervisory colleges as set forth in section 10-3-807 or otherwise;

(e) Enter into agreements with or obtain documentation from any insurer registered under section 10-3-804, any member of the internationally active insurance group, and any other state, federal, or international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation may not serve as evidence in any proceeding that an insurer or a person within an insurance holding company system, which insurer or person is not domiciled or incorporated in this state, is doing business in this state or is otherwise subject to jurisdiction in this state.

(f) Other group-wide supervision activities, consistent with the authorities and purposes described in this subsection (5), as the commissioner considers necessary.

(6) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the commissioner may

reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, so long as:

(a) The commissioner's cooperation is in compliance with the laws of this state; and

(b) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the commissioner may refuse recognition and cooperation.

(7) The commissioner may enter into agreements with or obtain documentation from any insurer registered under section 10-3-804, any affiliate of the insurer, or any other state, federal, or international regulatory agency for members of the internationally active insurance group, which agency provides the basis for or otherwise clarifies a regulatory official's role as group-wide supervisor.

(8) The commissioner may promulgate rules necessary for the administration of this section.

(9) A registered insurer subject to this section is liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

Source: L. 2019: Entire section added, (HB 19-1291), ch. 188, p. 2090, § 3, effective August 2.

10-3-808. Confidential treatment. (1) (a) Documents, materials, or other information in the possession or control of the division that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to section 10-3-806 and all information reported pursuant to section 10-3-803 (2)(l) and (2)(m), 10-3-804, or 10-3-805 are proprietary and contain trade secrets and are confidential by law and privileged; are not subject to the "Colorado Open Records Act", part 2 of article 72 of title 24; are not subject to subpoena; and are not subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer to which they pertain unless the commissioner, after giving the insurer and its affiliates who would be affected notice and opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication, in which event the commissioner may publish all or any part of the documents, materials, or other information in such manner as the commissioner deems appropriate.

(b) For purposes of the information reported and provided to the division pursuant to section 10-3-804 (12)(b), the commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company supervised by the federal reserve board or any United States group-wide supervisor.

(c) For the purposes of the information reported and provided to the division pursuant to section 10-3-804 (12)(f), the commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the federal reserve board and non-United States group-wide supervisors.

(2) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner or with whom the documents, materials, or other information are shared pursuant to this part 8 shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (1) of this section and proprietary and trade secret documents and materials, with other state, federal, and international regulatory agencies, with the NAIC, with any third-party consultants designated by the commissioner, and with state, federal, and international law enforcement authorities, including members of a supervisory college described in section 10-3-807, if the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information or proprietary and trade secret document and material and has verified in writing the legal authority to maintain confidentiality;

(b) Notwithstanding paragraph (a) of this subsection (3), shall share confidential and privileged documents, material, or information reported pursuant to section 10-3-804 (12) only with commissioners of states having statutes or regulations substantially similar to subsection (1) of this section and who have agreed in writing not to disclose such information;

(c) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information and proprietary and trade secret information, from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and shall maintain as confidential or privileged any document, material, or information or proprietary and trade secret documents and materials received with notice or the understanding that they are confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information or proprietary and trade secret document and material; and

(d) Shall enter into written agreements with the NAIC and any third-party consultant designated by the commissioner governing the sharing and use of information provided pursuant to this part 8 consistent with this subsection (3) that must:

(I) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this part 8, including procedures and protocols for sharing by the NAIC with other state, federal, or international regulators. The agreement must state that the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, or other information or proprietary and trade secret documents and materials and has verified in writing the legal authority to maintain such confidentiality.

(II) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this part 8 remains with the commissioner and that the use of the

information by the NAIC or the third-party consultant as designated by the commissioner is subject to the direction of the commissioner;

(II.5) Excluding documents, material, or information reported pursuant to section 10-3-804 (12)(f), prohibit the NAIC or a third-party consultant designated by the commissioner from storing the information shared pursuant to this section in a permanent database after the underlying analysis is completed;

(III) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or third-party consultant designated by the commissioner pursuant to this part 8 is subject to a request or subpoena to the NAIC or third-party consultant designated by the commissioner for disclosure or production;

(IV) Require the NAIC or a third-party consultant designated by the commissioner to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant designated by the commissioner may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this part 8; and

(V) For documents, materials, or information reported pursuant to section 10-3-804 (12)(f), where there is an agreement involving a third-party consultant, provide for notification of the identity of the consultant to the applicable insurers.

(4) The sharing of information by the commissioner pursuant to this part 8 does not constitute a delegation of regulatory authority or rule-making, and the commissioner is solely responsible for the administration, execution, and enforcement of this part 8.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information occurs as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (3) of this section.

(6) Documents, materials, or other information or proprietary and trade secret documents and materials in the possession or control of the NAIC or a third-party consultant designated by the commissioner pursuant to this part 8 are confidential by law and privileged; are not subject to the "Colorado Open Records Act", part 2 of article 72 of title 24; are not subject to subpoena; and are not subject to discovery or admissible in evidence in any private civil action.

(7) (a) The group capital calculation and resulting group capital ratio required by section 10-3-804 (12)(b) and the liquidity stress test along with its results and supporting disclosures required by section 10-3-804 (12)(f) are regulatory tools for assessing group risks and capital adequacy and group liquidity risks, respectively, and are not intended as a means to rank insurers or insurance holding company systems generally.

(b) (I) Except as provided in subsection (7)(b)(II) of this section, any insurer, broker, or other person engaged in any manner in the insurance business shall not advertise, announce, or state a representation regarding the group capital calculation, group capital ratio, liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by directly or indirectly making, publishing, disseminating, circulating, or placing the representation before the public:

(A) In a newspaper, a magazine, or other publication; or

(B) In the form of a notice, circular, pamphlet, letter, or poster; or

(C) Over any radio or television station or any electronic means of communication available to the public; or

(D) In any other way as an advertisement.

(II) An insurer may publish an announcement, advertisement, or statement described in subsection (7)(b)(I) of this section in a written publication if the sole purpose of the announcement is to rebut the materially false statement when the announcement, advertisement, or statement was published in a written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity or inappropriateness of such announcement, advertisement, or statement.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1348, § 2, effective July 1. **L. 2024:** (1), (3)(a), (3)(c), (3)(d), and (6) amended and (7) added, (HB 24-1321), ch. 252, p. 1667, § 4, effective January 1, 2025.

Editor's note: Subsection (1) is similar to former § 10-3-807 as it existed prior to 2014.

10-3-809. Rules. The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules and orders as are necessary to carry out this part 8.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1350, § 2, effective July 1.

Editor's note: This section is similar to former § 10-3-808 as it existed prior to 2014.

10-3-810. Injunctions - prohibitions against voting securities - sequestration of voting securities. (1) Whenever it appears to the commissioner that any insurer or any director, officer, employee, or agent of an insurer has committed or is about to commit a violation of this part 8 or of any rule or order issued by the commissioner under this part 8, the commissioner may apply to the district court for the county in which the principal officer of the insurer is located or, if the insurer has no office in this state, then to the district court for the city and county of Denver, for an order enjoining the insurer or director, officer, employee, or agent from violating or continuing to violate this part 8 or any rule or order, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

(2) (a) A security that is the subject of any agreement or arrangement regarding acquisition, or that is acquired or to be acquired, in contravention of this part 8 or of any rule or order issued by the commissioner under this part 8 shall not be voted at any shareholder's meeting or counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; but an action taken at any such meeting shall not be invalidated by the voting of the securities unless the action would materially affect control of the insurer or unless the courts of this state have so ordered.

(b) If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of this part 8 or of any rule or order issued by the commissioner under this part 8, the insurer or the commissioner may apply to the district court for the county in which the insurer has its principal place of business to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of section 10-3-803 or any rule or order issued by the commissioner under section 10-3-803 to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders,

and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

(3) If a person has acquired or is proposing to acquire any voting securities in violation of this part 8 or any rule or order issued by the commissioner under this part 8, the district court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner, seize or sequester any voting securities of the insurer owned directly or indirectly by the person and issue such order as may be appropriate to effectuate this part 8. Notwithstanding any other provision of law, for the purposes of this part 8, the situs of the ownership of the securities of domestic insurers is deemed to be in this state.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1350, § 2, effective July 1.

Editor's note: This section is similar to former § 10-3-809 as it existed prior to 2014.

10-3-811. Criminal proceedings - civil penalties - definition. (1) Whenever it appears to the commissioner that an insurer or a director, officer, employee, or agent thereof has committed a willful violation of this part 8, the commissioner may cause criminal proceedings to be instituted in the district court for the county in which the principal office of the insurer is located or, if such insurer has no such office in this state, in the district court for the city and county of Denver against such insurer or the insurer's responsible director, officer, employee, or agent. An insurer or individual that willfully violates this part 8 commits a class 6 felony and shall be punished as provided in section 18-1.3-401, C.R.S.

(2) (a) An insurer or an insurer's director, officer, employee, or agent that fails, without just cause, to file any registration statement, amendment, or notice of shareholder distribution as required in this part 8 may be required, after notice and hearing, to pay a civil penalty of not more than five thousand dollars for each violation. Each violation is a separate offense. The commissioner shall issue an order setting forth the amount of the civil penalty, which amount must be based on the alleged violator's history of previous violations, the good faith of the alleged violator in attempting to achieve rapid compliance after notification of the violation, the gravity and willfulness of the violation, the potential deterrent effect of the civil penalty, and such other considerations as may be specified by the commissioner. The commissioner may compromise, mitigate, or remit any such civil penalty.

(b) For purposes of this subsection (2), "civil penalty" means any monetary penalty levied against an insurer or an insurer's director, officer, employee, or agent because of a violation of this part 8. "Civil penalty" does not include any criminal penalty levied under subsection (1) of this section.

(c) The commissioner shall transmit all civil penalties collected pursuant to this subsection (2) to the state treasurer, who shall credit them to the general fund.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1351, § 2, effective July 1.

Editor's note: This section is similar to former § 10-3-810 as it existed prior to 2014.

10-3-812. Receivership. Whenever it appears to the commissioner that any person has committed a violation of this part 8 that so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, the commissioner may proceed as provided in part 4 or 5 of this article.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1352, § 2, effective July 1.

Editor's note: This section is similar to former § 10-3-811 as it existed prior to 2014.

10-3-813. Revocation, suspension, or nonrenewal of insurer's license. Whenever it appears to the commissioner that a person has committed a violation of this part 8 that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, suspend, revoke, or refuse to renew the insurer's license or authority to do business in this state for such period as the commissioner finds is required for the protection of policyholders or the public. The determination must be accompanied by specific findings of fact and conclusions of law.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1352, § 2, effective July 1.

Editor's note: This section is similar to former § 10-3-812 as it existed prior to 2014.

10-3-814. Judicial review - mandamus. (1) A person aggrieved by an act, determination, rule, order, or other action of the commissioner pursuant to this part 8 may appeal the action to the district court for the city and county of Denver. The court shall conduct its review without a jury and by trial de novo; except that, if all parties, including the commissioner, so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial de novo as to those parties so stipulating.

(2) The filing of an appeal pursuant to this section stays the application of the act, rule, order, or other action of the commissioner to the appealing party unless the court, after giving the parties notice and an opportunity to be heard, determines that a stay would be detrimental to the interests of policyholders, shareholders, creditors, or the public.

(3) A person aggrieved by a failure of the commissioner to act or make a determination required by this part 8 may petition the district court for the city and county of Denver for an action in the nature of a mandamus or a peremptory mandamus directing the commissioner to act or make such determination forthwith.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1352, § 2, effective July 1.

Editor's note: This section is similar to former § 10-3-813 as it existed prior to 2014.

10-3-815. Recovery of distributions or payments. (1) Subject to the limitations of this section, where a distribution or payment pursuant to paragraph (a) or (b) of this subsection (1) is made at any time during the one year preceding a petition for liquidation, conservation, or rehabilitation, as the case may be, if an order for liquidation or rehabilitation of a domestic

insurer has been entered, the receiver appointed under the order may recover on behalf of the insurer:

(a) From any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions other than distributions of shares of the same class of stock paid by the insurer on its capital stock; or

(b) Any payment in the form of a bonus, termination settlement, or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer, or employee.

(2) A distribution is not recoverable if the parent or affiliate shows that, when paid, the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) A person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid is liable up to the amount of distributions or payments under subsection (1) of this section that the person received. A person who otherwise controlled the insurer at the time the distributions were declared is liable up to the amount of distributions that would have been received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(4) The maximum amount recoverable under this section is the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse the Colorado insurance guaranty association, as that term is defined in section 10-3-502 (9).

(5) To the extent that a person liable under subsection (3) of this section is insolvent or otherwise fails to pay claims due from it, its parent corporation, holding company, or a person who otherwise controlled it at the time the distribution was paid is jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation, holding company, or person who otherwise controlled it.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1353, § 2, effective July 1.

Editor's note: This section is similar to former § 10-3-814 as it existed prior to 2014.

10-3-816. Conflict with other laws. All laws and parts of laws of this state inconsistent with this part 8 are hereby superseded with respect to matters covered by this part 8.

Source: L. 2014: Entire part R&RE, (SB 14-152), ch. 312, p. 1354, § 2, effective July 1.

PART 9

UNAUTHORIZED INSURANCE

10-3-901. Short title. This part 9 shall be known and may be cited as the "Regulation of Unauthorized Insurance Act".

Source: L. 67: p. 873, § 10. **C.R.S. 1963:** § 72-25-10.

10-3-902. Legislative declaration. The purpose of this part 9 is to subject certain persons and insurers to the jurisdiction of the commissioner, of proceedings before the commissioner, and of the courts of this state in suits. The general assembly declares that it is a subject of concern that many residents of this state hold policies of insurance issued by persons and insurers not authorized to do insurance business in this state, thus presenting to such residents the often insuperable obstacle of asserting their legal rights under such policies in forums foreign to them under laws and rules of practice with which they are not familiar and are deprived of the benefit of Colorado laws regulating insurance. The general assembly declares that it is also concerned with the protection of residents of this state against acts by persons and insurers not authorized to do an insurance business in this state by the maintenance of fair and honest insurance markets; by protecting the premium tax revenues of this state; by protecting authorized persons and insurers, which are subject to strict regulation, from unfair competition by unauthorized persons and insurers; and by protecting against the evasion of the insurance regulatory laws of this state. In furtherance of such state interest, the general assembly in this part 9 exercises its power to protect residents of this state and to define what constitutes transacting insurance business in this state.

Source: L. 67: p. 868, § 1. **C.R.S. 1963:** § 72-25-1.

10-3-903. Definition of transacting insurance business. (1) Any of the following acts in this state, effected by mail or otherwise, by an unauthorized insurer constitute transacting insurance business in this state as the term is used in section 10-3-105:

(a) The making of, or proposing to make, as an insurer, an insurance contract;

(b) The making of, or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;

(c) The taking or receiving of any application for insurance;

(d) The receiving or collection of any premium, commission, membership fees, assessments, dues, or other consideration for any insurance or any part thereof;

(e) The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state;

(f) Directly or indirectly acting as an agent for or otherwise representing, or aiding on behalf of another, any person or insurer in the solicitation, negotiation, procurement, or effectuation of insurance or renewals thereof; or in the dissemination of information as to coverage or rates; or in the forwarding of applications; or in the delivery of policies or contracts; or in the inspection of risks; or in the fixing of rates; or in the investigation or adjustment of claims or losses; or in the transaction of matters subsequent to the effectuation of the contract and arising out of it; or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state. The provisions of this paragraph (f) shall not operate to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance on behalf of such employer.

(g) The doing of any kind of insurance business specifically recognized as constituting the doing of an insurance business within the meaning of the statutes relating to insurance;

(h) The doing, or proposing to do, any insurance business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of the statutes;

(i) Any other transactions of business in this state by an insurer;

(j) Funding, either directly or indirectly, the cash qualification bond of a cash-bonding agent or professional cash-bail agent when the means do not constitute an arm's-length transaction under reasonable commercial standards or where the agreement to repay is contingent on the volume or value of the bonds posted;

(k) Except for payments from the defendant or a third-party indemnitor who applied for the bond, paying, either directly or indirectly, for the forfeiture of a bail bond posted by a cash-bonding agent or professional cash-bail agent when the payment is made by a person other than the cash-bonding agent or professional cash-bail agent that posted the bail bond.

(2) This section does not apply to:

(a) The lawful transaction of surplus lines insurance;

(b) The lawful transaction of reinsurance by insurers;

(c) Transactions in this state involving a policy lawfully solicited, written, and delivered outside of this state covering only subjects of insurance not resident, located, or expressly to be performed in this state at the time of issuance, and which transactions are subsequent to the issuance of such policy;

(d) Transactions involving contracts of insurance independently procured through negotiations occurring entirely outside of this state which are reported and on which premium tax is paid;

(e) Attorneys acting in the ordinary relation of attorney and client in the adjustment of claims or losses;

(f) Transactions in this state involving group life or group annuities where the master policy of such groups was lawfully issued and delivered in a state in which the company was authorized to do an insurance business;

(g) The transaction of business by a home warranty service company pursuant to part 9 of article 10 of title 12;

(h) Transactions in this state involving group sickness and accident or blanket sickness and accident insurance where the master policy was lawfully issued and delivered to a single employer in another state in which the company was authorized to do an insurance business, when a master policy which covers residents of this state includes mammography benefits at a level at least as comprehensive as those required by section 10-16-104 (18)(b.5);

(i) Any transaction in this state involving the issuance of a charitable gift annuity, as defined in section 10-1-102 (4);

(j) The sale of authorized insurance by agents of a motor vehicle rental company if such sale complies with the limitations set forth in section 10-2-105 (2)(g);

(k) Repealed.

(l) A person licensed as a cash-bonding agent or professional cash-bail agent under article 23 of this title, unless the person engages in conduct described in subsection (1) of this section.

Source: L. 67: p. 868, § 2. **C.R.S. 1963:** § 72-25-2. **L. 79:** (2)(g) added, p. 582, § 2, effective June 7. **L. 91:** (2)(f) amended and (2)(h) added, p. 1213, § 6, effective July 1. **L. 92:** (2)(h) amended, p. 1750, § 1, effective May 29; (2)(h) amended, p. 1750, § 2, effective July 1. **L.**

95: (2)(i) added, p. 218, § 2, effective April 17. **L. 98:** (2)(j) added, p. 234, § 4, effective April 10. **L. 2001:** (2)(j) amended, p. 1213, § 37, effective January 1, 2002. **L. 2003:** (2)(i) amended, p. 617, § 11, effective July 1; (2)(k) added, p. 1784, § 15, effective July 1. **L. 2006:** (2)(k) amended, p. 1998, § 31, effective July 1. **L. 2009:** (2)(h) amended, (HB 09-1204), ch. 344, p. 1806, § 3, effective January 1, 2010. **L. 2012:** IP(1) amended and (1)(j), (1)(k), and (2)(l) added, (HB 12-1266), ch. 280, p. 1507, § 36, effective July 1. **L. 2015:** IP(2) and (2)(g) amended, (HB 15-1223), ch. 81, p. 235, § 6, effective August 5. **L. 2018:** (2)(k) repealed, (HB 18-1431), ch. 313, p. 1891, § 7, effective August 8. **L. 2019:** (2)(g) amended, (HB 19-1172), ch. 136, p. 1651, § 32, effective October 1. **L. 2020:** (2)(h) amended, (HB 20-1402), ch. 216, p. 1042, § 11, effective June 30.

Cross references: (1) For reinsurance, see part 7 of this article 3; for surplus line insurance, see article 5 of this title 10.

(2) For the legislative declaration contained in the 1998 act enacting subsection (2)(j), see section 1 of chapter 88, Session Laws of Colorado 1998. For the legislative declaration contained in the 2009 act amending subsection (2)(h), see section 1 of chapter 344, Session Laws of Colorado 2009.

10-3-903.5. Jurisdiction over providers of health-care benefits - rules. (1) Notwithstanding any other provision of law, and except as provided in this section, any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the division of insurance, unless such person or entity shows that while providing such services it is subject to the jurisdiction of another agency of this state, any subdivisions thereof, or the federal government.

(2) A person or other entity may show that it is subject to the jurisdiction of another agency of this state, any subdivision thereof, or the federal government, by providing to the insurance commissioner the appropriate certificate, license, or other document issued by the other governmental agency which permits or qualifies it to provide those services. Nothing in this section shall be construed to in any way limit the ability of the division of insurance to regulate insurance companies, multiple employer trusts, multiple employer welfare arrangements, association health plans, or preferred provider organizations.

(3) Any person or other entity which is unable to show under subsection (2) of this section that it is subject to the jurisdiction of another agency of this state, any subdivision thereof, or the federal government shall submit to an examination by the insurance commissioner to determine the organization and solvency of the person or the entity, and to determine whether such person or entity complies with the applicable provisions of this article.

(4) Any person or other entity unable to show that it is subject to the jurisdiction of another agency of this state, any subdivision thereof, or the federal government shall be subject to all appropriate provisions of this article regarding the conduct of its business.

(5) Any production agency or administrator which advertises, sells, transacts, or administers the coverage in this state described in subsection (1) of this section and which is required to submit to an examination by the insurance commissioner under subsection (3) of this section shall, if said coverage is not fully insured or otherwise fully covered by an admitted

sickness and accident insurer, nonprofit hospital, medical, surgical, and health service corporation, prepaid dental care plan, or health maintenance organization, advise every purchaser, prospective purchaser, and covered person of such lack of insurance or other coverage.

(6) Any administrator which advertises or administers the coverage in this state described in subsection (1) of this section and which is required to submit to an examination by the insurance commissioner under subsection (3) of this section, shall advise any production agency of the elements of the coverage, including the amount of "stop-loss" insurance in effect.

(7) (a) The provisions of this section and any other laws of this state that regulate insurance or insurance companies shall not apply to any multiple employer health trust that meets the requirements of subsection (7)(b) of this section, any multiple employer welfare arrangement that meets the requirements of subsection (7)(c) of this section, or any multiple employer behavioral health trust that meets the requirements of subsection (7)(e) of this section. Any such trust or arrangement shall be subject to the requirements of this subsection (7) and section 10-3-1104. The exemption provided by this subsection (7) shall not apply to any entity if the division of insurance determines that its operation is hazardous to the public or to individuals receiving benefits.

(b) A multiple employer health trust is any trust that is:

(I) Sponsored, maintained, and funded by one or more entities of state government or political subdivisions of the state organized pursuant to state law and is for the benefit of the entity's employees, including a multiple employer health trust established for the purposes of part 3 or 4 of article 5 of title 29; or

(II) Established and maintained pursuant to the provisions of a collective bargaining agreement between one or more unions and employers or an association of employers for the benefit of employees who are covered by such agreement, and pursuant to which health benefits, wages, pension benefits, and other terms of employment have been bargained for in good faith and the sponsoring union provides services and benefits to its members other than health benefits.

(c) A multiple employer welfare arrangement is any arrangement that complies with either the following requirements or subsection (7)(d) of this section:

(I) The multiple employer welfare arrangement shall have been in existence continuously since at least January 1, 1983, and shall maintain unallocated reserves of not less than five percent of the first two million dollars of annual contributions made to such arrangement in the preceding year.

(II) The multiple employer welfare arrangement shall file its annual financial statement with the division within sixty days after the end of its fiscal year to demonstrate that the required reserves are being maintained, and it shall file its audited financial statement with the division within the time period that insurance companies are required to file such statements.

(III) The multiple employer welfare arrangement shall file an actuarial opinion with the division which states that the reserves and the contribution and funding levels of the arrangement are adequate and which includes the underlying actuarial report in support of the opinion in accordance with the requirements of section 10-7-114, and such arrangement shall file such opinion and report within the time period that insurance companies are required to file such actuarial opinion.

(IV) The multiple employer welfare arrangement shall provide benefits which are in substantial compliance with the mandated benefit provisions that are applicable to insurers offering health insurance coverage in this state.

(V) The multiple employer welfare arrangement shall be sponsored and maintained by an association which:

(A) Has within its membership the employers who participate in and fund the arrangement;

(B) Is engaged in substantial activities for its employer members, other than the sponsorship of an employee welfare benefit plan, and provides business or professional assistance and benefits to its members who share a common business interest and are primarily engaged in the same trade or business; and

(C) Has been in existence for a period of at least ten years.

(d) (I) A multiple employer welfare arrangement that meets the requirements specified in subsection (7)(c) of this section other than subsection (7)(c)(I) of this section may file an application for a waiver with the commissioner. A multiple employer welfare arrangement that meets the requirements specified in subsection (7)(c) of this section other than those specified in subsections (7)(c)(I) and (7)(c)(V)(B) of this section may also file an application for a waiver with the commissioner. The application must include:

(A) A copy of the multiple employer welfare arrangement's articles of incorporation, constitution, trust agreement, bylaws, and analogous organic documents that govern the operation of the arrangement;

(B) A copy of membership criteria, a statement of ownership of the multiple employer welfare arrangement's members, and a summary of the activities and benefits, other than health plan coverage, provided to members;

(C) A list of names, addresses, and official capacities with the multiple employer welfare arrangement of the individuals who will be responsible for the management and conduct of the affairs of the arrangement, including all trustees, officers, and directors, along with a full disclosure of the extent and nature of any contracts between the individuals and the arrangement, including possible conflicts of interest;

(D) Background records. Each individual specified in subsection (7)(d)(I)(C) of this section shall submit a set of fingerprints to the commissioner. The commissioner shall forward the fingerprints to the Colorado bureau of investigation for the purpose of conducting a state and national fingerprint-based criminal history record check utilizing records of the Colorado bureau of investigation and the federal bureau of investigation. The multiple employer welfare arrangement shall bear only the actual costs of the record check. When the results of a fingerprint-based criminal history record check of an individual performed pursuant to this subsection (7)(d)(I)(D) reveal a record of arrest without a disposition, the commissioner shall require that individual to submit to a name-based judicial record check, as defined in section 22-2-119.3 (6)(d).

(E) A copy of the policy, contract, certificate, summary plan description, or other evidence of the benefits and coverages provided to covered employees, including for each form of evidence a table of the rates charged or proposed to be charged;

(F) A copy of the multiple employer welfare arrangement's stop-loss or excess insurance agreement, if any;

(G) A copy of audited financial statements of the multiple employer welfare arrangement for the previous five years that were prepared by a licensed certified public accountant, including an actuarial opinion; and

(H) A copy of every contract between the multiple employer welfare arrangement and its administrator or service company, including, if applicable, a copy of the fidelity bond specified in subsection (7)(d)(II)(C) of this section.

(II) To qualify for a waiver, a multiple employer welfare arrangement must:

(A) Maintain unallocated reserves of not less than two million dollars of minimum surplus; except that the commissioner may, by rule, increase the minimum surplus consistent with the standards of the national association of insurance commissioners;

(B) Be managed by and provide benefits through an administrator or service company that is in good standing in all other states in which the administrator or service company operates, and if the multiple employer welfare arrangement provides coverage through one or more brokers, the brokers must be licensed as producers pursuant to article 2 of this title 10;

(C) Be managed by an administrator or service company that is a licensed third-party administrator or is covered by a fidelity bond in the amount of two hundred thousand dollars;

(D) Maintain a complaint system that complies with article 11 of this title 10 and make the system available to the division upon request;

(E) File the multiple employer welfare arrangement's plan marketing materials with the division;

(F) Provide to the commissioner quarterly financial statements to demonstrate that the reserves required pursuant to subsection (7)(d)(II)(A) of this section are being maintained along with annual audited financial reports;

(G) Provide nondiscriminatory plan coverage to its members that is applied evenly and equitably to all employees of the members and that matches what is otherwise required of health benefit plans, including: Coverage of essential health benefit plans and compliance with the federal "Patient Protection and Affordable Care Act", Pub.L.111-148, as amended; coverage of state-mandated health benefits as required by section 10-16-104; network provider requirements and compliance with network adequacy standards as required by section 10-16-704; and guarantee issue requirements, including that all multiple employer welfare arrangement members and their employees must be eligible to purchase insurance;

(H) Not condition membership on health-status-related factors related to an individual or exclude an employer from membership because of the health status of the employees of the employer. Health-status-related factors include: Health status; medical condition, including both physical and mental illness, as defined in 45 CFR 144.103; and evidence of insurability or disability.

(I) Not charge different premium rates, alter cost sharing, or change benefit levels based on health-status-related factors of a multiple employer welfare arrangement member group or individual employee of that group;

(J) Not make health insurance coverage offered through the arrangement available other than in connection with a member of the multiple employer welfare arrangement; and

(K) File annual rate and form filings with the division as specified by the commissioner by rule.

(III) The commissioner shall consider granting a waiver to a multiple employer welfare arrangement that has submitted a complete application pursuant to subsection (7)(d)(I) of this

section and that is in compliance with subsection (7)(d)(II) of this section in accordance with the following factors:

(A) Whether the establishment of a multiple employer welfare arrangement has the potential to lower insurance costs for its members or provide additional insurance options in a region or regions of the state where there may not be sufficient competition;

(B) Potential impact on the fully insured market;

(C) Consumer experience with accessing coverage and the potential for consumer harm;

(D) Whether the administrator of the multiple employer welfare arrangement has demonstrated financial soundness so as to not jeopardize the viability of the arrangement or harm its members; and

(E) The length of time the multiple employer welfare arrangement has been in existence.

(IV) A waiver granted pursuant to this subsection (7)(d) subjects the multiple employer welfare arrangement to the division's full enforcement authority available pursuant to this title 10 and allows the arrangement to operate pursuant to this subsection (7) for two years. To continue to operate pursuant to this subsection (7), an arrangement must reapply for a waiver; except that, if the commissioner grants five consecutive waivers pursuant to this subsection (7)(d), an arrangement may continue to operate pursuant to this subsection (7) without again applying for a waiver. An arrangement operating pursuant to this subsection (7)(d) remains subject to the division's full enforcement authority under this title 10, and the division may apply any requirement in this title 10 applicable to health insurance carriers to the arrangement as long as the multiple employer welfare arrangement is operating in Colorado.

(V) The commissioner:

(A) Shall adopt rules for the implementation of this subsection (7)(d); and

(B) May waive any of the requirements of subsection (7)(d)(I)(B) of this section for waiver applicants that meet the requirements in subsection (7)(c) of this section other than those specified in subsections (7)(c)(I) and (7)(c)(V)(B) of this section.

(e) A multiple employer behavioral health trust is any trust that is sponsored and maintained by one or more entities of state government or political subdivisions of the state, organized pursuant to state law, and funded by the state for the benefit of the entities' employees, including a multiple employer behavioral health trust established for the purposes of part 5 of article 5 of title 29.

Source: L. 91: Entire section added, p. 1206, § 3, effective July 1. **L. 93:** (7) added, p. 256, § 1, effective March 31. **L. 2014:** IP(7)(b) and (7)(b)(I) amended, (SB 14-172), ch. 325, p. 1427, § 2, effective January 1, 2015. **L. 2017:** (7)(b)(I) amended, (SB 17-214), ch. 187, p. 684, § 4, effective May 3. **L. 2021:** IP(7)(c) amended and (7)(d) added, (SB 21-063), ch. 467, p. 3360, § 1, effective September 7. **L. 2022:** (7)(d)(I)(D) amended, (HB 22-1270), ch. 114, p. 513, § 5, effective April 21; (7)(a) amended and (7)(e) added, (SB 22-002), ch. 339, p. 2443, § 8, effective June 3.

10-3-904. Commissioner may enjoin unauthorized company. Whenever the commissioner of insurance believes, from evidence satisfactory to him, that any foreign or alien company is violating the provisions of section 10-3-105 and this part 9, the commissioner may, through the attorney general of this state, cause a complaint to be filed in the district court in and for the city and county of Denver to enjoin and restrain such company from continuing such

violation or engaging therein or doing any act in furtherance thereof. The court has jurisdiction of the proceeding and has the power to make and enter an order or judgment awarding such preliminary or final injunctive relief as in its judgment is proper.

Source: L. 67: p. 869, § 3. **C.R.S. 1963:** § 72-25-3.

10-3-904.5. Emergency cease-and-desist orders - issuance - rules - definition. (1) The commissioner may issue an emergency cease-and-desist order ex parte if:

(a) The commissioner believes that:

(I) An unauthorized person is engaging in the business of insurance in violation of section 10-3-105 or 10-3-903 or is in violation of a rule promulgated by the commissioner; or

(II) A person is failing to remedy or has not remedied a deficiency or deficiencies in the submission required pursuant to section 10-16-107.4 (1) within the thirty days after the commissioner levies an initial fine pursuant to section 10-16-107.4 (2)(b)(II); and

(b) It appears to the commissioner that the alleged conduct is fraudulent, creates an immediate danger to the public safety, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

(2) For purposes of subsection (1) of this section, "unauthorized person" means any individual, corporation, association, partnership, or other natural or artificial person that directly or indirectly engages in the transaction of insurance business as described in section 10-3-903, except as such business may be engaged in in accordance with specific authorization in this title.

(3) Upon making a determination under subsection (1) of this section that an emergency cease-and-desist order should be issued, the commissioner shall serve on the person who is the subject of the order, by registered or certified mail, return receipt requested, at such person's last-known address, an order that contains a statement of the charges and requires such person to immediately cease and desist from the acts, methods, or practices stated in the order.

(4) The division of insurance shall promulgate reasonable rules necessary to carry out the provisions of this section and sections 10-3-904.6 and 10-3-904.7. Such rules shall include, to the extent possible, provisions requiring uniformity with respect to the procedures of this state and other states, the United States, and the national association of insurance commissioners.

Source: L. 93: Entire section added, p. 334, § 1, effective July 1. **L. 2022:** (1)(a) amended, (HB 22-1269), ch. 444, p. 3129, § 2, effective June 8.

10-3-904.6. Emergency cease-and-desist orders - hearings - judicial review - violations. (1) Any person who is the subject of an emergency cease-and-desist order may contest such order by requesting an immediate hearing before the commissioner, pursuant to section 24-4-105 (12), C.R.S., at which such person shall have the opportunity to show cause why the order should not be affirmed or upheld. Any immediate hearing requested by a person against whom an emergency cease-and-desist order has been issued pursuant to the provisions of this section shall be held in accordance with the requirements of article 4 of title 24, C.R.S. The commissioner shall have all of the powers provided in such article for the party conducting the hearing.

(2) Upon good cause shown the commissioner shall permit any person to intervene, appear, and be heard at the hearing, either in person or through counsel.

(3) Following the hearing the commissioner shall affirm, modify, or set aside, in whole or in part, the emergency cease-and-desist order.

(4) Any person adversely affected by the commissioner's decision may appeal such decision by filing an action for judicial review in the court of appeals pursuant to the provisions of section 24-4-106 (11), C.R.S. Any appeal made pursuant to the provisions of this subsection (4) shall not operate to stay or vacate a decision or order of the commissioner unless the court issues an order that specifically stays or vacates the order or decision. The commissioner may recover reasonable attorney fees if judicial action is necessary to enforce an order made pursuant to section 10-3-904.5.

(5) The commissioner shall be responsible for determining whether an emergency cease-and-desist order has been violated and may conduct a hearing pursuant to the procedures in section 24-4-105, C.R.S., to assist in making such determination. If the commissioner determines that a violation has occurred, notice of a hearing shall be mailed by the commissioner to the alleged violator's last-known address. Such notice shall contain the time, date, and place of the hearing to be held for the purpose of eliciting further information. Hearings shall not be held before the twenty-first day after the date the notice is sent. The notice shall contain a statement of the facts or conduct alleged to be in violation of the emergency cease-and-desist order. If after a hearing the commissioner determines that an emergency cease-and-desist order has been violated the commissioner may:

(a) Impose a civil penalty of twenty-five thousand dollars for each act of violation;

(b) Direct the person against whom the order was issued to make complete restitution, in the form and amount and within the period determined by the commissioner, to all state residents, insureds, and entities operating in this state that were damaged by the violation or failure to comply; or

(c) Impose the penalty described in paragraph (a) of this subsection (5) and direct restitution pursuant to the provisions of paragraph (b) of this subsection (5).

(6) Any person adversely affected by an order issued by the commissioner pursuant to subsection (5) of this section may appeal such order by commencing an action for judicial review in the court of appeals pursuant to section 24-4-106 (11), C.R.S. Any such action shall be commenced no later than the twentieth day after the date of the order. The division may recover reasonable attorney fees if judicial action is necessary for enforcement of the commissioner's order.

Source: L. 93: Entire section added, p. 334, § 1, effective July 1.

10-3-904.7. Failure to pay penalties or restitution. (1) If a person fails to pay a penalty or make complete restitution as directed by the commissioner under section 10-3-904.6 (5)(a) or (5)(b), the commissioner may:

(a) Refer the matter to the attorney general for enforcement; or

(b) Cancel or revoke any permit, license, certificate of authority, certificate, registration, or other authorization issued to such person.

Source: L. 93: Entire section added, p. 334, § 1, effective July 1.

10-3-905. Service of process upon unauthorized company. (1) Any act of entering into a contract of insurance as an insurer, or transacting insurance business in this state, as such term is defined by section 10-3-903, by an unauthorized foreign or alien company is equivalent to and constitutes an appointment by such company of the commissioner to be its true and lawful attorney upon whom may be served all lawful process in any action or proceeding against it arising out of a violation of this part 9, or any action which may arise under the terms of this part 9, and the performance of one or more of such acts is signification of its agreement that any such process against it which is so served is of the same legal force and validity as if served upon the company.

(2) (a) Service of such process shall be made by delivering and leaving with the commissioner two copies thereof and the payment to the commissioner of a fee of ten dollars. The commissioner shall promptly mail by certified mail one of the copies of such process to such company at its last-known principal place of business and shall keep a record of all process so served upon the commissioner. Such process is sufficient service upon such company if notice of such service and a copy of the process are, within ten days thereafter, sent by certified mail, by or on behalf of the commissioner, to such company at its last-known principal place of business, and the return receipt of the company or, in the event the company refuses to accept such certified mail, the certified mail with its refusal thereon and the affidavit of compliance herewith by or on behalf of the commissioner is filed with the clerk of the court in which such action or proceeding is pending. The date of filing of the return receipt or refusal and affidavit of compliance constitutes the effective date of service and sufficient proof thereof.

(b) Notwithstanding the amount specified for the fee in paragraph (a) of this subsection (2), the commissioner by rule or as otherwise provided by law may reduce the amount of the fee if necessary pursuant to section 24-75-402 (3), C.R.S., to reduce the uncommitted reserves of the fund to which all or any portion of the fee is credited. After the uncommitted reserves of the fund are sufficiently reduced, the commissioner by rule or as otherwise provided by law may increase the amount of the fee as provided in section 24-75-402 (4), C.R.S.

(3) The court in any action or proceeding in which service is made in the manner provided in subsection (2) of this section may, in its discretion, order such postponement as may be necessary to afford such company reasonable opportunity to defend such action or proceeding.

(4) Nothing in this section is to be construed to prevent an unauthorized foreign or alien company from filing a motion to quash a writ or to set aside service thereof made in the manner provided in subsection (2) of this section on the ground that such unauthorized company has not done any of the acts referred to in section 10-3-903.

(5) No judgment by default shall be entered in any such action or proceeding until the expiration of thirty days from the date of the filing of the affidavit of compliance.

(6) Nothing in this section shall limit or affect the right to serve any process, notice, or demand required or permitted by law to be served upon any company in any other manner permitted by law.

Source: L. 67: p. 870, § 4. **C.R.S. 1963:** § 72-25-4. **L. 71:** p. 731, § 1. **L. 86:** (2) amended, p. 555, § 5, effective July 1. **L. 89:** (2) amended, p. 437, § 7, effective July 1. **L. 98:** (2) amended, p. 1326, § 27, effective June 1.

10-3-906. Validity of insurance contracts - liability under insurance contract. (1) The failure of a company transacting insurance business in Colorado to obtain a certificate of authority shall not impair the validity of any act or contract of such company and shall not prevent such company from defending any action in any court of this state.

(2) In event of failure of any such unauthorized insurer to pay any claim or loss within the provisions of such insurance contract, any person who assisted or in any manner aided directly or indirectly in the procurement of such insurance contract is also liable to the insured for the full amount of the claim or loss in the manner provided by the provisions of such insurance contract.

Source: L. 67: p. 870, § 5. **C.R.S. 1963:** § 72-25-5.

10-3-907. Investigation and disclosure of insurance contracts. (1) Whenever the commissioner has reason to believe that insurance has been effectuated by or for any person in this state with an unauthorized insurer, the commissioner shall in writing order such person to produce for examination all insurance contracts and other documents evidencing insurance with both authorized and unauthorized insurers and to disclose to the commissioner the amount of insurance, name and address of each insurer, gross amount of premium paid or to be paid, and the name and address of the person assisting or aiding in the solicitation, negotiation, or effectuation of such insurance.

(2) Every person who, for thirty days after such written order pursuant to subsection (1) of this section, neglects to comply with the requirements of such order or who willfully makes a disclosure that is untrue, deceptive, or misleading shall forfeit fifty dollars, and an additional fifty dollars for each day of neglect after expiration of said thirty days.

Source: L. 67: p. 871, § 6. **C.R.S. 1963:** § 72-25-6.

10-3-908. Reporting of unauthorized insurance. (1) Every person investigating or adjusting any loss or claim on a subject of insurance in this state shall immediately report to the commissioner every insurance policy or contract which has been entered into by any insurer not authorized to transact such insurance business in this state.

(2) Every person acting in the capacity of insurance adviser, counselor, or analyst shall report to the commissioner every insurance policy or contract covering a subject of insurance in this state which has been entered into by an insurer not authorized to transact such insurance business in this state.

(3) This section does not apply to transactions in this state involving a policy lawfully solicited, written, and delivered outside of this state covering only subjects of insurance not resident, located, or expressly to be performed in this state at the time of issuance, and which transactions are subsequent to the issuance of such policy.

Source: L. 67: p. 871, § 7. **C.R.S. 1963:** § 72-25-7.

10-3-909. Unauthorized insurance premium tax. (1) Except as to premiums that are subject to a federal premium, excise, or stamp tax equal to or in excess of three percent of net premiums, and except as to premiums on independently procured insurance on which tax has

been paid pursuant to section 10-3-209, 10-5-111, or 10-5-111.5, every insured under a contract procured from an unauthorized insurer shall pay to the division of insurance before March 1 next succeeding the calendar year in which the insurance was so effectuated, continued, or renewed a premium tax of three percent of net premiums charged for the insurance. Such insurance on subjects resident, located, or to be performed in this state procured through negotiations or an application, in whole or in part occurring or made within or from within or outside of this state, or for which premiums in whole or in part are remitted directly or indirectly from within or outside of this state, is deemed to be insurance procured, continued, or renewed in this state. The term "premium" includes all premiums, membership fees, assessments, dues, and any other consideration for insurance. If the tax prescribed by this section is not paid within the time stated, the tax is increased by a penalty of twenty-five percent and by the amount of an additional penalty computed at the rate of one percent per month or any part thereof from the date the payment was due to the date paid.

(2) If a policy covers risks or exposures only partially in this state, the tax payable shall be computed on the portions of the premium which are properly allocable to the risks or exposures located in this state.

(3) Proration of premium taxes due from an industrial insured under a contract procured from an unauthorized insurer having property in states other than Colorado shall be determined by rules and regulations promulgated by the commissioner using the following criteria where applicable:

(a) Percentage of physical assets in Colorado;

(b) Percentage of employee payroll in Colorado;

(c) Percentage of sales in Colorado;

(d) Percentage of taxable income reportable in Colorado.

Source: L. 67: p. 871, § 8. **C.R.S. 1963:** § 72-25-8. **L. 2012:** (1) amended, (HB 12-1215), ch. 104, p. 354, § 6, effective August 8. **L. 2023:** (1) amended, (HB 23-1111), ch. 46, p. 173, § 2, effective January 1, 2024.

Cross references: For the legislative declaration in HB 23-1111, see section 1 of chapter 46, Session Laws of Colorado 2023.

10-3-910. Application of this part 9. (1) Other than section 10-3-909, this part 9 shall not apply to any insurance company or underwriter issuing contracts of insurance to industrial insureds nor to any contract of insurance issued to any one or more industrial insureds.

(2) For purposes of this section, an "industrial insured" is:

(a) An insured who procures the insurance of any risk other than life and annuity contracts by use of the services of a full-time employee acting as an insurance manager or buyer or the services of a regularly and continuously retained qualified insurance consultant who does not receive a commission or compensation for placing the risk; and

(b) An insured whose aggregate annual premiums for insurance on all risks total at least one hundred thousand dollars; and

(c) An insured having at least one hundred full-time employees.

(3) Repealed.

Source: L. 67: p. 872, § 9. **C.R.S. 1963:** § 72-25-9. **L. 95:** (2) amended, p. 497, § 19, effective May 16. **L. 98:** (3)(a) amended, p. 1326, § 28, effective June 1. **L. 2022:** (3) repealed, (HB 22-1025), ch. 145, p. 944, § 1, effective August 10.

PART 10

UNAUTHORIZED INSURERS PROCESS ACT

10-3-1001. Short title. This part 10 shall be known and may be cited as the "Unauthorized Insurers Process Act".

Source: L. 55: p. 478, § 6. **CRS 53:** § 72-19-5. **C.R.S. 1963:** § 72-18-5.

10-3-1002. Legislative declaration. The purpose of this part 10 is to subject certain insurers to the jurisdiction of courts of this state in suits by or on behalf of insureds or beneficiaries under insurance contracts. The general assembly declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers while not authorized to do business in this state, thus presenting to such residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies. In furtherance of such state interest, the general assembly provides in this part 10 a method of substituted service of process upon such insurers and declares that in so doing it exercises its power to protect its residents and to define, for the purpose of this part 10, what constitutes doing business in this state, and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, Chapter 20, 1st Sess., S. 340, as amended, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

Source: L. 55: p. 475, § 1. **CRS 53:** § 72-19-1. **C.R.S. 1963:** § 72-18-1.

10-3-1003. Service of process upon unauthorized insurer. (1) Any of the following acts in this state, effected by mail or otherwise, by an unauthorized foreign or alien insurer: The issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business therein; the solicitation of applications for such contracts; the collection of premiums, membership fees, assessments, or other considerations for such contracts; or any other transaction of insurance business, is equivalent to and constitutes an appointment by such insurer of the commissioner and his successor in office to be its true and lawful attorney, upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such contract of insurance; and any such act shall be signification of its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon such insurer.

(2) Such service of process shall be made by delivering to and leaving with the commissioner or some person in apparent charge of his office two copies thereof and the payment to him of ten dollars which shall be taxed as part of costs of the proceeding. The commissioner shall forthwith mail by certified mail one of the copies of such process to the defendant at its last-known principal place of business and shall keep a record of all process so

served upon him. Such service of process is sufficient, if notice of such service and a copy of the process are sent within ten days thereafter by certified mail by plaintiff or plaintiff's attorney to the defendant at its last-known principal place of business, and if the defendant's receipt or receipt issued by the post office with which the letter is certified, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear or within such further time as the court may allow.

(3) Service of process in any such action, suit, or proceeding shall, in addition to the manner provided in subsection (2) of this section, be valid if served upon any person within this state who, in this state on behalf of such insurer, is soliciting insurance, or making, issuing, or delivering any contract of insurance, or collecting or receiving any premium, membership fee, assessment, or other consideration for insurance, and if a copy of such process is sent within ten days thereafter by registered mail by the plaintiff or plaintiff's attorney to the defendant at the last-known principal place of business of the defendant, and if the defendant's receipt or the receipt issued by the postoffice with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear or within such further time as the court may allow.

(4) No plaintiff or complainant shall be entitled to a judgment by default under this section until the expiration of thirty days from date of the filing of the affidavit of compliance.

(5) Nothing in this section shall limit or abridge the right to serve any process, notice, or demand upon any insurer in any other manner permitted by law.

Source: L. 55: p. 476, § 2. **CRS 53:** § 72-19-2. **C.R.S. 1963:** § 72-18-2. **L. 86:** (2) amended, p. 555, § 6, effective July 1. **L. 89:** (2) amended, p. 437, § 8, effective July 1.

10-3-1004. Defense of action by unauthorized insurer. (1) Before any unauthorized foreign or alien insurer files or causes to be filed any pleading in any action, suit, or proceeding instituted against it, the unauthorized insurer shall either deposit cash or securities with the clerk of the court in which such action, suit, or proceeding is pending or file with the clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment that may be rendered in such action, or procure a certificate of authority to transact the business of insurance in this state, unless one or more of the following is applicable:

(a) The insurer makes a showing satisfactory to the court and the commissioner that there are, in this state or in another state, cash, securities, bond, or other assets sufficient and available to secure the payment of any final judgment which may be rendered in the action, suit, or proceeding or that the insurance was placed lawfully in the jurisdiction in which the transaction took place and which was not an unlawful placement under the laws of this state;

(b) At the time the insurer files any pleading in any action, suit, or proceeding instituted against it, the insurer is listed on the eligible nonadmitted insurers list prepared by the commissioner pursuant to subsection (1) of section 10-5-108;

(c) With respect to a contract of reinsurance, the reinsurer has complied with the provisions of this title necessary to permit the ceding insurer to take credit on its financial statement for the reinsurance pursuant to part 7 of this article.

(1.5) If an insurer or reinsurer asserts an exemption under paragraph (a), (b), or (c) of subsection (1) of this section, such insurer or reinsurer shall notify the court of the basis on which the exemption is sought and shall file a copy of the assertion with the commissioner of insurance.

(2) The court, in any action, suit, or proceeding in which service is made in the manner provided in section 10-3-1003 (2) or (3), may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (1) of this section and to defend such action.

(3) Nothing in subsection (1) of this section is to be construed to prevent an unauthorized foreign or alien insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in section 10-3-1003 (2) or (3) on the ground either that such unauthorized insurer has not done any of the acts enumerated in section 10-3-1003 (1) or that the person on whom service was made pursuant to section 10-3-1003 (3) was not doing any of the acts therein enumerated.

Source: L. 55: p. 477, § 3. **CRS 53:** § 72-19-3. **C.R.S. 1963:** § 72-18-3. **L. 97:** (1) amended and (1.5) added, p. 531, § 5, effective April 24. **L. 2012:** (1)(b) amended, (HB 12-1215), ch. 104, p. 355, § 8, effective August 8. **L. 2014:** IP(1) and (1)(c) amended, (HB 14-1315), ch. 295, p. 1217, § 5, effective January 1, 2015.

10-3-1005. Attorney fees. In any action against an unauthorized foreign or alien insurer upon a contract of insurance issued or delivered in this state to a resident thereof or to a corporation authorized to do business therein, if the insurer has failed for thirty days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include such fee in any judgment that may be rendered in such action. Such fee shall not exceed twelve and one-half percent of the amount which the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall such fee be less than twenty-five dollars. Failure of an insurer to defend any such action is deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

Source: L. 55: p. 478, § 4. **CRS 53:** § 72-19-4. **C.R.S. 1963:** § 72-18-4.

PART 11

UNFAIR COMPETITION - DECEPTIVE PRACTICES

Editor's note: This part 11 was numbered as article 14 of chapter 72, C.R.S. 1963. The substantive provisions of this part 11 were repealed and reenacted in 1973, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to

this part 11 prior to 1973, consult the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

Law reviews: For article, "Insurance Bad Faith in Colorado", see 14 Colo. Law. 1157 (1985); for article, "The Showpiece Homes Decision: From Caveat Emptor to Insurer Beware?", see 31 Colo. Law. 73 (April 2002).

10-3-1101. Legislative declaration. (1) The purpose of this part 11 is to regulate trade practices in the business of insurance by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices, and by prohibiting the trade practices so defined or determined. No rules or regulations may be promulgated to adversely affect free and open competition in the sale of insurance.

(2) It is in the best interests of the citizens of this state to have transparency in the insurance claims process to further the public policy of encouraging settlement and preventing unnecessary litigation. Claimants and injured parties should fully understand the total amount of insurance coverage available to them. In addition, because payment of uninsured and underinsured motorist benefits covers the difference between the amount of the limits of any legal liability coverage and the amount of the damages sustained, it is important that the citizens of this state have accurate and reliable information about the amount of legal liability coverage available for a claim. Providing information to Colorado residents concerning the amount of liability coverage will:

(a) Help Colorado residents evaluate whether their uninsured or underinsured motorist coverage will be triggered; and

(b) Allow an insurer who provides uninsured or underinsured motorist coverage or policies more time to evaluate and place reserves on claims.

Source: L. 73: R&RE, p. 857, § 1. **C.R.S. 1963:** § 72-14-1. **L. 2019:** Entire section amended, (HB 19-1283), ch. 250, p. 2426, § 1, effective January 1, 2020.

10-3-1102. Definitions. As used in this part 11, unless the context otherwise requires:

(1) "Commissioner" means the commissioner of insurance.

(2) "Insurance policy" or "insurance contract" means any contract of insurance, indemnity, medical or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any person.

(2.5) Repealed.

(3) "Person" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, nonadmitted insurer, fraternal benefit society, and other legal entities engaged in the insurance business, including agents, limited insurance representatives, agencies, brokers, surplus line brokers, and adjusters. The term also includes medical service plans and hospital service plans regulated under parts 1 and 3 of article 16 of this title 10, health maintenance organizations regulated under parts 1 and 4 of article 16 of this title 10, and multiple employer welfare arrangements operating pursuant to section 10-3-903.5 (7)(d). The plans, arrangements, and organizations shall be deemed to be engaged in the business of insurance for purposes of this part 11 only.

Source: L. 73: R&RE, p. 857, § 1. **C.R.S. 1963:** § 72-14-2. **L. 78:** (2.5) added, p. 293, § 1, effective July 1. **L. 81:** (2.5) repealed, p. 577, § 5, effective June 4. **L. 84:** (3) amended, p. 331, § 1, effective July 1. **L. 87:** (3) amended, p. 425, § 1, effective May 1. **L. 92:** (3) amended, p. 1723, § 4, effective July 1. **L. 95:** (3) amended, p. 491, §5, effective May 16. **L. 2021:** (3) amended, (SB 21-063), ch. 467, p. 3363, § 2, effective September 7.

10-3-1103. Unfair methods of competition - unfair or deceptive acts or practices - prohibited. No person shall engage in this state in any trade practice which is defined in this part 11 as, or determined pursuant to section 10-3-1107 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Source: L. 73: R&RE, p. 858, § 1. **C.R.S. 1963:** § 72-14-3.

10-3-1104. Unfair methods of competition - unfair or deceptive practices - rules - definitions. (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

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

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

(II) Misrepresents the dividends or share of the surplus to be received on any insurance policy; or

(III) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; or

(IV) Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; or

(V) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; or

(VI) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy; or

(VII) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(VIII) Misrepresents any insurance policy as being a security; or

(IX) Misrepresentation shall not be construed where a written comparison of policies is made factually disclosing relevant features and benefits for which the policy is issued and by which an informed decision can be made;

(b) False information and advertising generally:

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

(II) Knowingly filing with the commissioner or other public official, or with any employee or agent of the division of insurance in the department of regulatory agencies, a written, false statement of material fact as to the financial condition of an insurer;

(III) Knowingly making any false entry of a material fact in any book, report, or other written statement of any insurer; knowingly omitting or failing to make a true entry of a material fact pertaining to the business of the insurer in any book, report, or other written statement of the insurer; or knowingly making any written, false material statement to the commissioner or any employee or agent of the division of insurance in the department of regulatory agencies;

(c) Defamation: Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical, or derogatory to the financial condition of any person, and which is calculated to injure such person;

(d) Boycott, coercion, and intimidation: Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(e) Stock operations and advisory board contracts: Issuing or delivering, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares, in any corporation, or securities, or any special or advisory board contracts, or other contracts of any kind promising returns and profits as an inducement to insurance;

(f) (I) Unfair discrimination: Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract;

(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;

(III) Making or permitting to be made any classification solely on the basis of marital status or sex, unless such classification is for the purpose of insuring family units or is justified by actuarial statistics;

(IV) Making or permitting to be made any classification solely on the basis of blindness, partial blindness, or a specific physical disability unless such classification is based upon an unequal expectation of life or an expected risk of loss different than that of other individuals;

(V) Repealed.

(VI) Inquiring about or making an investigation concerning, directly or indirectly, an applicant's, an insured's, or a beneficiary's sexual orientation in:

(A) An application for coverage; or

(B) Any investigation conducted in connection with an application for coverage;

(VII) Using information about gender, marital status, medical history, occupation, residential living arrangements, beneficiaries, zip codes, or other territorial designations to determine sexual orientation;

(VIII) Using sexual orientation in the underwriting process or in the determination of insurability;

(IX) Making adverse underwriting decisions because an applicant or an insured has demonstrated concerns related to AIDS by seeking counseling from health-care professionals;

(X) Making adverse underwriting decisions on the basis of the existence of nonspecific blood code information received from the medical information bureau, but this prohibition shall not bar investigation in response to the existence of such nonspecific blood code as long as the investigation is conducted in accordance with the provisions of section 10-3-1104.5;

(XI) Reducing benefits under a health insurance policy by the addition of an exclusionary rider, unless such rider only excludes conditions which have been documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition;

(XII) Denying health-care coverage subject to article 16 of this title to any individual based solely on that individual's casual or nonprofessional participation in the following activities: Motorcycling; snowmobiling; off-highway vehicle riding; skiing; or snowboarding;

(XIII) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy of sickness and accident insurance, in the benefits payable under such policy, in the terms or conditions of the policy, or in any other manner;

(XIV) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling, or limiting the amount of insurance coverage on a property and casualty risk solely because of the geographic location of the risk, unless the action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience;

(XV) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, canceling, or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property;

(XVI) Terminating or modifying coverage or refusing to issue or renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired; except that this subparagraph (XVI) does not:

(A) Apply to accident and health insurance sold by a casualty insurer; or

(B) Modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract;

(XVII) Refusing to insure a person solely because another insurer has refused to write a policy, or has canceled or has refused to renew an existing policy, in which the person was the named insured. Nothing in this subparagraph (XVII) prevents an insurer from terminating an excess insurance policy based on the failure of the insured to maintain any required underlying insurance.

(g) Rebates: Except as otherwise provided in this section and as otherwise expressly provided by law, knowingly permitting, or offering to make, or making any contract of insurance or agreement as to such contract, other than as plainly expressed in the insurance contract issued thereon, or paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly,

as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits on the contract or annuity, or any valuable consideration or inducement whatever not specified in the contract; or giving, selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance contract or annuity or in connection with the insurance contract or annuity, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued on the stocks, bonds, or other securities, or anything of value whatsoever not specified in the contract;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(I) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; or

(II) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies; or

(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or

(IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information; or

(V) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; or

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; or

(VII) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; or

(VIII) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application; or

(IX) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured; or

(X) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made; or

(XI) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; or

(XII) Delaying the investigation or payment of claims by requiring an insured or claimant, or the physician of either of them, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; or

(XIII) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(XIV) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or

(XV) Raising as a defense or partial offset in the adjustment of a third-party claim the defense of comparative negligence as set forth in section 13-21-111, C.R.S., without conducting a reasonable investigation and developing substantial evidence in support thereof. At such time as the issue is raised under this subparagraph (XV), the insurer shall furnish to the commissioner a written statement setting forth reasons as to why a defense under the comparative negligence doctrine is valid.

(XVI) Excluding medical benefits under health-care coverage subject to article 16 of this title to any covered individual based solely on that individual's casual or nonprofessional participation in the following activities: Motorcycling; snowmobiling; off-highway vehicle riding; skiing; or snowboarding; or

(XVII) Failing to adopt and implement reasonable standards for the prompt resolution of medical payment claims;

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

(j) Misrepresentation in insurance applications: Making false or fraudulent statements or representations on or relative to any application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any person;

(k) Requiring, directly or indirectly, any insured or claimant to submit to any polygraph test concerning any application for or any claim under any policy of insurance;

(l) Violation of or noncompliance with any insurance law in part 6 of article 4 of this title;

(m) Failure to make promptly a full refund or credit of all unearned premiums to the person entitled thereto upon termination of insurance coverage;

(n) Requiring or attempting to require or otherwise induce a health-care provider, as defined in section 13-64-403 (12)(a), C.R.S., to utilize arbitration agreements with patients as a condition of providing medical malpractice insurance to such health-care provider;

(o) Failure to comply with all the provisions of section 10-3-1104.5 regarding HIV testing;

(p) Violation of or noncompliance with any provision of part 13 of this article;

(q) Increasing the premiums unilaterally or decreasing the coverage benefits on renewal of a policy of insurance, increasing the premium on new policies, or failing to issue an insurance policy to barbers, cosmetologists, estheticians, nail technicians, barbershops, or beauty salons, as regulated in article 105 of title 12, regardless of the type of risk insured against, based solely on the decision of the general assembly to stop mandatory inspections of the places of business of such insureds;

(r) Repealed.

(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or

certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

(t) Certifying pursuant to section 10-4-419 or issuing, soliciting, or using a claims-made policy form, endorsement, or disclosure form that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(u) Certifying pursuant to section 10-4-633 or issuing, soliciting, or using an automobile policy form, endorsement, or notice form that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(v) Failure to comply with all provisions of section 10-16-108.5 concerning fair marketing of health benefit plans and section 10-16-105 concerning guaranteed issuance of individual and small employer health benefit plans;

(w) Failure to comply with the provisions of section 10-16-105.1 concerning the renewability of health benefit plans;

(x) Violation of the provisions of part 8 of article 1 of title 25, C.R.S., concerning patient records;

(y) Violating any provision of the "Consumer Protection Standards Act for the Operation of Managed Care Plans", part 7 of article 16 of this title, by those subject to said part 7;

(z) Willfully violating any provision of section 10-16-113.5;

(aa) Certifying pursuant to section 10-10-109 (3) or 10-10-109 (4), issuing, soliciting, or using a credit insurance policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider that does not comply with Colorado law. Such certification, issuance, solicitation, or use shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(bb) Certifying pursuant to section 10-15-105 (1), issuing, soliciting, or using a preneed funeral contract form or a form of assignment that does not comply with Colorado law. Such certification, issuance, solicitation, or use shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(cc) Violation of the provisions of section 10-16-122 (4) concerning an unauthorized transfer of a covered person or subscriber's prescription;

(dd) Failing to comply with the provisions of section 10-4-628 (2)(a)(V) or 10-16-201 (5);

(ee) Willfully or repeatedly violating section 10-11-108 (1)(c) or (1)(d), including a willful or repeated violation through the creation or operation of an improper affiliated business arrangement;

(ff) Violation of the "Physician and Dentist Designation Disclosure Act", article 38 of title 25, C.R.S.;

(gg) Violation of section 10-16-705 (6.5) or (10.5);

(hh) Unfair compensation practices: Basing the compensation of claims employees or contracted claims personnel, including compensation in the form of performance bonuses or incentives, on any of the following:

(I) The number of policies canceled;

(II) The number of times coverage is denied;

(III) The use of a quota limiting or restricting the number or volume of claims; or

(IV) The use of an arbitrary quota or cap limiting or restricting the amount of claims payments without due consideration of the merits of the claim;

(ii) Violation of section 8-43-401.5, C.R.S.;

(jj) Violation of part 6 of article 43 of title 8, C.R.S.;

(kk) Violation of section 10-7-703 of the "Insurable Interest Act", part 7 of article 7 of this title;

(ll) Engaging in stranger originated life insurance;

(mm) Paying a fee or rebate or giving or promising anything of value to a jailer, peace officer, clerk, deputy clerk, an employee of a court, district attorney or district attorney's employees, or a person who has power to arrest or to hold a person in custody as a result of writing a bail bond;

(nn) Unless the indemnitor consents in writing otherwise, failure to post a bail bond within twenty-four hours after receipt of full payment or a signed contract for payment, and if the bail bond is not posted within twenty-four hours after receipt of full payment or a signed contract for payment, failure to refund all moneys received, release all liens, and return all collateral within seven days after receipt of good funds;

(oo) Failure to report, preserve without use, retain separately, or return after payment in full, collateral taken as security on any bail bond to the principal, indemnitor, or depositor of the collateral;

(pp) Soliciting bail bond business in or about any place where prisoners are confined, arraigned, or in custody;

(qq) Failure to pay a final, nonappealable judgment award for failure to return or repay collateral received to secure a bond;

(rr) Certifying pursuant to section 8-44-102, C.R.S., or issuing, soliciting, or using a workers' compensation form, endorsement, rider, letter, or notice that does not comply with statutory mandates. The solicitation or certification is subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(ss) A violation of section 10-16-704 (3)(d) or (5.5);

(tt) A violation of part 15 of article 16 of this title 10.

(2) Nothing in subsection (1)(f) or (1)(g) of this section shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, if any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

(c) Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(d) Requests by a person that an applicant or insured take an HIV related test when such request has been prompted by either the health history or current condition of the applicant or

insured or by threshold coverage amounts which are applied to all persons within the risk class, as long as such test is conducted in accordance with the provisions of section 10-3-1104.5.

(e) Offering or providing, by or through an employee, affiliate, or third-party representative of an insurer or insurance producer, a value-added product or service at no cost or reduced cost, when the product or service is not specified in the insurance policy, if the product or service:

(I) Relates to the insurance coverage; and

(II) Is primarily aimed to achieve one or more of the following:

(A) Provide loss mitigation or loss control;

(B) Reduce claim costs or claim settlement costs;

(C) Provide education about liability risk or risk of loss to individuals or property;

(D) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;

(E) Enhance health;

(F) Promote financial wellness through items such as educational or financial planning services;

(G) Provide post-loss services;

(H) Encourage behavioral changes to improve the health or reduce the risk of death or disability of a customer; or

(I) Assist in the administration of employee or retiree benefit insurance coverage.

(2.1) The cost to an insurer or insurance producer offering a product or service to a customer pursuant to subsection (2)(e) of this section must be reasonable in comparison to that customer's premiums or insurance coverage.

(2.2) If an insurer or insurance producer is offering a product or service pursuant to subsection (2)(e) of this section, the insurer or insurance producer shall provide a customer with contact information to assist the customer with questions regarding the product or service.

(2.3) To ensure consumer protection while implementing the permitted practices set forth in subsection (2) of this section, the commissioner may adopt rules to implement and enforce subsections (2) to (2.7) of this section.

(2.4) The availability of a product or service offered pursuant to subsection (2)(e) of this section must be:

(a) Based on documented, objective criteria that is maintained by the insurer or insurance producer and must be produced upon request by the division; and

(b) Offered in a manner that is not unfairly discriminatory.

(2.5) (a) If an insurer or insurance producer does not have sufficient evidence but has a good faith belief that a product or service meets the criteria set forth in subsections (2)(e)(II)(A) to (2)(e)(II)(I) of this section, the insurer or insurance producer shall provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.

(b) (I) An insurer or insurance producer shall notify and receive approval from the division for a pilot or testing program prior to launching the program.

(II) The division shall approve or deny a pilot or testing program no later than thirty days after receiving notification pursuant to subsection (2.5)(b)(I) of this section.

(2.6) (a) An insurer or insurance producer may:

(I) Offer or give a noncash gift, item, or service, including a meal or charitable donation, to or on behalf of a customer in connection with the marketing, sale, purchase, or retention of an insurance contract if the cost does not exceed an amount determined to be reasonable by the commissioner per policy year per term; or

(II) Offer or give a noncash gift, item, or service, including a meal or charitable donation, to or on behalf of a customer, including a commercial or institutional customer, in connection with the marketing, sale, purchase, or retention of an insurance contract if:

(A) The cost is reasonable in comparison to the premium or proposed premium; and

(B) The cost of the gift, item, or service is not included in any amount charged to another person or entity.

(b) (I) Any offer or gift made pursuant to this subsection (2.6) must be offered in a manner that is not unfairly discriminatory.

(II) An insurer or insurance producer shall not require a customer to purchase, continue, or renew an insurance policy in exchange for a gift, item, or service received pursuant to this subsection (2.6).

(2.7) Except as applied to an insurer or insurance producer's offer of a value-added product or service, an insurer or insurance producer shall not:

(a) Offer or provide insurance as an inducement to the purchase of another policy; or

(b) Use the words "free" or "no cost" or words of similar import in an advertisement.

(3) Repealed.

(4) The following is defined as an unfair practice in the business of insurance: For an insurer to deny, refuse to issue, refuse to renew, refuse to reissue, cancel, or otherwise terminate a motor vehicle insurance policy, to restrict motor vehicle insurance coverage on any person, or to add any surcharge or rating factor to a premium of a motor vehicle insurance policy solely because of:

(a) A conviction under section 18-13-122 (3), or section 44-3-901 (1)(c), or any counterpart municipal charter or ordinance offense or because of any driver's license revocation resulting from such conviction. This subsection (4)(a) includes, but is not limited to, a driver's license revocation imposed under section 42-2-125 (1)(m) prior to its repeal in 2021.

(b) The licensee's inability to operate a motor vehicle due to physical incompetence if the licensee obtains an affidavit from a rehabilitation provider or licensed physician acceptable to the department of revenue.

(5) It shall not be an unfair practice in the business of insurance for an insurer to pay an assignee if the insurer believes in good faith that the claim is subject to a written assignment from the insured. The insurer shall remain responsible to the insured for such amounts pursuant to the applicable policy terms in the event the person paid did not hold a written assignment and did not provide services or goods to the insured at the insured's request.

(6) As used in this section, unless the context otherwise requires:

(a) "Customer" includes a policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured, or applicant.

(b) "Insurance producer" has the meaning set forth in section 10-2-103 (6).

Source: L. 73: R&RE, p. 858, § 1. **C.R.S. 1963:** § 72-14-4. **L. 75:** (1)(f)(III) added, p. 341, § 1, effective July 1. **L. 78:** (1)(f)(IV) added, p. 295, § 1, effective March 21; (3) added, p. 293, § 2, effective March 24. **L. 79:** IP(1)(h) amended and (1)(l) added, p. 359, § 5, effective

June 22; (1)(h)(XV) added, p. 383, § 1, effective July 1. **L. 80:** (1)(f)(V) added, p. 751, § 2, effective April 10. **L. 81:** (3) repealed, p. 577, § 5, effective June 4. **L. 88:** (1)(m) and (1)(n) added, pp. 340, 625, §§ 3, 4, effective July 1. **L. 89:** (1)(f)(VI) to (1)(f)(X), (1)(o), and (2)(d) added, pp. 448, 449, §§ 2-4, effective April 12; (1)(p) added p. 451, § 2, effective July 1. **L. 90:** (1)(q) added, p. 770, § 29, effective July 1. **L. 92:** (1)(r) added, p.1503, § 1, effective April 16; (1)(t) and (1)(u) added, p. 1555, § 52, effective May 20; (1)(f)(XI) added, p. 1750, § 3, effective May 29; (1)(s) added, p. 1744, § 3, effective June 2. **L. 93:** (1)(s) amended, p. 1390, § 6, effective January 1, 1995. **L. 94:** (1)(v) added, p. 1920, § 13, effective July 1. **L. 96:** (1)(w) added, p. 459, § 2, effective July 1. **L. 97:** (1)(x) added, p. 350, § 4, effective April 19; (1)(y) added, p. 1332, § 4, effective July 1; (4) added, p. 1044, § 6, effective August 6; (1)(f)(XII) and (1)(h)(XVI) added, p. 68, §§ 1, 2, effective October 1. **L. 98:** (4)(a) amended, p. 817, § 8, effective August 5. **L. 99:** (5) added, p. 312, § 2, effective August 4; (1)(z) added, p. 1056, § 3, effective June 1, 2000. **L. 2000:** (4)(b) amended, p. 1635, § 7, effective June 1; (1)(aa) and (1)(bb) added, p. 464, § 2, effective August 2. **L. 2001:** (1)(r) amended, p. 1051, § 36, effective July 1; (1)(cc) added, p. 1231, § 3, effective January 1, 2002. **L. 2002:** (1)(f)(XII) and (1)(h)(XVI) amended, p. 65, § 1, effective January 1, 2003. **L. 2003:** (1)(u) amended, p. 1571, § 4, effective July 1. **L. 2004:** (1)(l) amended, p. 902, § 21, effective May 21; (1)(h)(XVII) added, p. 1102, § 2, effective July 1. **L. 2005:** (1)(dd) added, p. 221, § 3, effective April 14. **L. 2006:** (1)(ee) added, p. 269, § 4, effective July 1. **L. 2008:** (1)(ff) added, p. 2017, § 2, effective September 1. **L. 2009:** (1)(gg) added, (HB 09-1061), ch. 197, p. 886, § 2, effective August 5. **L. 2010:** (1)(hh) added, (SB 10-076), ch. 228, p. 987, § 1, effective May 17; (1)(ii) added, (SB 10-011), ch. 302, p. 1433, § 5, effective May 27; (1)(b) amended and (1)(f)(XIII), (1)(f)(XIV), (1)(f)(XV), (1)(f)(XVI), and (1)(f)(XVII) added, (HB 10-1220), ch. 197, p. 851, §§ 6, 7, effective July 1; (1)(jj) added, (SB 10-178), ch. 290, p. 1350, § 2, effective July 1. **L. 2011:** (1)(kk) and (1)(ll) added, (SB 11-182), ch. 227, p. 976, § 2, effective May 27. **L. 2012:** (1)(mm), (1)(nn), (1)(oo), (1)(pp), and (1)(qq) added, (HB 12-1266), ch. 280, p. 1507, § 37, effective July 1. **L. 2013:** (1)(v) and (1)(w) amended, (HB 13-1266), ch. 217, p. 986, § 42, effective May 13; (1)(r) amended, (HB 13-1115), ch. 338, p. 1970, § 4, effective May 28. **L. 2014:** (4)(a) amended, (SB 14-129), ch. 387, p. 1937, § 4, effective June 6; (1)(rr) added, (SB 14-137), ch. 78, p. 317, § 2, effective August 6. **L. 2015:** (1)(q) amended, (SB 15-106), ch. 122, p. 384, § 20, effective May 1; (1)(ff) amended, (HB 15-1191), ch. 95, p. 274, § 8, effective August 5. **L. 2018:** (4)(a) amended, (HB 18-1025), ch. 152, p. 1077, § 5, effective October 1. **L. 2019:** (1)(q) amended, (HB 19-1172), ch. 136, p. 1651, § 33, effective October 1; (1)(ss) added, (HB 19-1174), ch. 171, p. 1982, § 2, effective January 1, 2020. **L. 2021:** (4)(a) amended, (HB 21-1314), ch. 460, p. 3099, § 8, effective January 1, 2022. **L. 2022:** (1)(tt) added, (HB 22-1122), ch. 312, p. 2233, § 2, effective August 10. **L. 2025:** (1)(g) and IP(2) amended and (2)(e), (2.1), (2.2), (2.3), (2.4), (2.5), (2.6), (2.7), and (6) added, (SB 25-058), ch. 84, p. 348, § 1, effective August 6.

Editor's note: (1) Subsection (1)(f)(V) provided for the repeal of subsection (1)(f)(V), effective July 1, 1987. (See L. 1980, p. 751.)

(2) Subsection (1)(r)(II) provided for the repeal of subsection (1)(r), effective March 31, 2015. (See L. 2013, p. 1970.)

(3) Section 2(2) of chapter 84 (SB 25-058), Session Laws of Colorado 2025, provides that the act changing this section applies to conduct occurring on or after August 6, 2025.

Cross references: For the legislative declaration contained in the 2000 act enacting subsections (1)(aa) and (1)(bb), see section 1 of chapter 135, Session Laws of Colorado 2000.

10-3-1104.5. HIV testing - legislative declaration - definitions - requirements for testing - limitations on disclosure of test results - penalty. (1) The general assembly declares that a balance must be maintained between the need for information by those conducting the business of insurance and the public's need for fairness in practices for testing for the human immunodeficiency virus, including the need to minimize intrusion into an individual's privacy and the need to limit disclosure of the results of such testing.

(2) As used in this section, unless the context otherwise requires:

(a) "AIDS" means acquired immunodeficiency syndrome.

(b) "Applicant" means the individual proposed for coverage.

(c) "HIV" means human immunodeficiency virus.

(d) "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS.

(e) "HIV related test" means any laboratory test or series of tests for any virus, antibody, antigen, or etiologic agent whatsoever thought to cause or to indicate the presence of AIDS.

(f) "Person" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the insurance business, except insurance agents and brokers. Such term shall also include medical service plans and hospital service plans regulated under parts 1 and 3 of article 16 of this title and health maintenance organizations regulated under parts 1 and 4 of article 16 of this title. Such plans and health maintenance organizations shall be deemed to be engaged in the business of insurance for purposes of this section.

(3) No person shall request or require that an applicant submit to an HIV related test unless that person:

(a) Obtains the applicant's prior written informed consent; and

(b) Reveals, in the written consent form, and explains the use of the HIV related test result to the applicant and entities to whom test results may be disclosed pursuant to paragraphs (a) and (b) of subsection (4) of this section; and

(c) Provides the applicant with:

(I) Printed material prior to testing which contains factual information describing AIDS; its causes, symptoms, and transmission; and the tests used to detect HIV infection and what a person should do if the result of the HIV related test is positive; or

(II) Information on how to obtain relevant counseling from a qualified practitioner having extensive training and experience in addressing the fears, questions, and concerns of persons tested for HIV infection; and

(d) Administers the HIV related test based upon the following test protocol, as a minimum:

(I) Two positive ELISA tests and a western blot test with bands present at p24, p31, and either gp41 or gp160; or

(II) An equally reliable screening or confirmatory test protocol designated by the commissioner, with the approval of the department of public health and environment; and

(e) Discloses the results of testing in the manner prescribed by subsection (4) of this section.

(4) (a) On the basis of the applicant's written informed consent as specified in subsection (3) of this section, a person may disclose an individual applicant's HIV related test results to its reinsurers or to those contractually retained medical personnel, laboratories, and insurance affiliates, excluding agents and brokers, which are involved in underwriting decisions regarding the individual's application if disclosure is necessary to make underwriting decisions regarding such application.

(b) Other than the disclosures permitted by paragraph (a) of this subsection (4), no person shall disclose HIV related test results which identify the individual applicant with the test results obtained to anyone without first obtaining separate written informed consent for such disclosure from the applicant; except that, if the result of the HIV related test of an applicant is positive or indeterminate, such person may report the test finding to the medical information bureau but only if a nonspecific blood test result code is used which does not indicate that the applicant was tested for HIV infection.

(c) Nothing in this subsection (4) shall be construed to prohibit reporting as required by the provisions of section 25-4-405, C.R.S.

(5) A person shall notify the applicant in writing of an adverse underwriting decision based upon the results of such applicant's blood test but shall not disclose the specific results of such blood test to such applicant. The person shall also inform the applicant that the results of the blood test will be sent to the physician designated by the applicant at the time of application and that such physician should be contacted for information regarding the HIV related test. If a physician was not designated at the time of application, the person shall request that the applicant name a physician to whom a copy of the blood test can be sent.

(6) Notwithstanding any other provisions to the contrary, any person who fails to comply with all the provisions of this section regarding the disclosure of HIV-related test results commits a class 2 misdemeanor.

Source: L. 89: Entire section added, p. 446, § 1, effective April 12. **L. 92:** (2)(f) amended, p. 1724, § 5, effective July 1. **L. 94:** (3)(d)(II) amended, p. 2723, § 318, effective July 1. **L. 2016:** (4)(c) amended, (SB 16-146), ch. 230, p. 914, § 4, effective July 1. **L. 2021:** (6) amended, (SB 21-271), ch. 462, p. 3148, § 115, effective March 1, 2022.

Cross references: For the penalty for a class 2 misdemeanor, see § 18-1.3-501.

10-3-1104.6. Genetic information - limitations on disclosure of information - liability - definitions - legislative declaration. (1) The general assembly hereby finds and determines that recent advances in genetic science have led to improvements in the diagnosis, treatment, and understanding of a significant number of human diseases. The general assembly further declares that:

(a) Genetic information is the unique property of the individual to whom the information pertains;

(b) Any information concerning an individual obtained through the use of genetic services may be subject to abuses if disclosed to unauthorized third parties without the willing consent of the individual to whom the information pertains;

(c) To protect individual privacy and to preserve individual autonomy with regard to the individual's genetic information, it is appropriate to limit the use and availability of genetic information;

(d) The intent of this section is to prevent genetic information from being used to deny access to health-care insurance or medicare supplement insurance coverage.

(2) For the purposes of this section:

(a) "Entity" means any sickness and accident insurance company, health maintenance organization, nonprofit hospital, medical-surgical and health service corporation, or other entity that provides health-care insurance or medicare supplement insurance coverage and is subject to the jurisdiction of the commissioner of insurance.

(b) "Family member" means an individual who is related to another individual by blood, adoption, or marriage within the first, second, third, or fourth degree.

(c) (I) "Genetic information" means information about an individual's genetic test, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members of the individual. "Genetic information" includes any request for, or receipt of, genetic services with respect to an individual, or participation by an individual or the family member of an individual in clinical research that includes genetic services.

(II) With regard to an individual who is pregnant, "genetic information" includes genetic information of the fetus carried by the pregnant individual. With regard to an individual or family member using reproductive technology, "genetic information" includes genetic information of any embryo legally held by an individual or family member.

(III) "Genetic information" does not include information about the sex or age of an individual.

(d) "Genetic services" means a genetic test, genetic counseling, which includes obtaining, interpreting, or assessing genetic information, or genetic education.

(e) (I) "Genetic test" means any analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes.

(II) "Genetic test" does not include:

(A) An analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health-care professional with appropriate training and expertise in the field of medicine involved; or

(B) An analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes.

(f) "Underwriting purposes" means any of the following:

(I) Rules for, or determination of, eligibility for enrollment or continued eligibility in a policy or for benefits under the policy;

(II) The computation of premium or contribution amounts under the policy;

(III) The application of any preexisting condition exclusion under the policy; and

(IV) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(3) (a) Genetic information shall be confidential and privileged. Any release, for purposes other than diagnosis, treatment, or therapy, of genetic information that identifies the person tested with the test results released requires specific written consent by the person about whom the genetic information pertains or the parent or guardian of that person.

(b) (I) Any entity that receives genetic information may not seek, use, or keep the information for any nontherapeutic purpose or for any underwriting purpose connected with the provision of health-care insurance or medicare supplement insurance coverage.

(II) If an entity obtains genetic information incidental to a request or requirement for, or purchase of, other information concerning an individual, the request or requirement for, or purchase of, such information shall not be considered a violation of this paragraph (b) if it is not in violation of paragraph (a) of this subsection (3).

(c) (I) An entity shall not request or require an individual or family member of the individual to undergo a genetic test unless otherwise authorized by applicable state or federal law.

(II) Nothing in this paragraph (c) shall be construed to preclude an entity from obtaining and using the results of a genetic test in making a determination regarding payment, as defined in 45 CFR 164.501, as may be amended, and consistent with paragraphs (a) and (b) of this subsection (3).

(4) Notwithstanding the provisions of subsection (3) of this section, in the course of a criminal investigation or a criminal prosecution, and to the extent allowed under the federal or state constitution, any peace officer, district attorney, or assistant attorney general, or a designee thereof, may obtain genetic information regarding the identity of any individual who is the subject of the criminal investigation or prosecution for use exclusively in any criminal investigation or prosecution without the consent of the individual being tested.

(5) Notwithstanding the provisions of subsection (3) of this section, any research facility may use genetic information for scientific research purposes if the identity of any individual to whom the information pertains is not disclosed to any third party; except that the individual's identity may be disclosed to the individual's physician if the individual consents to the disclosure in writing.

(6) This section does not limit the authority of a court or any party to a parentage proceeding to use genetic information for purposes of determining parentage pursuant to section 13-25-126, C.R.S.

(7) This section does not limit the authority of a court or any party to a proceeding that is subject to the limitations of part 5 of article 64 of title 13, C.R.S., to use genetic information for purposes of determining the cause of damage or injury.

(8) This section does not limit the authority of the state board of parole to require any offender who is involved in a sexual assault to submit to blood tests and to retain the results of such tests on file as authorized under section 17-2-201 (5)(g), C.R.S.

(9) This section does not limit the authority granted the state department of public health and environment, the state board of health, or county, district, or municipal public health agencies pursuant to section 25-1-122, C.R.S.

(10) Any violation of this section is an unfair practice as defined in section 10-3-1104 (1), and is subject to the provisions of sections 10-3-1106 to 10-3-1113.

(11) Any individual who is injured by an entity's violation of this section may recover in a court of competent jurisdiction the following remedies:

(a) Equitable relief, which may include a retroactive order, directing the entity to provide health insurance or medicare supplement insurance coverage, whichever is appropriate, to the injured individual under the same terms and conditions as would have applied had the violation not occurred; and

(b) The greater of:

(I) An amount equal to any actual damages suffered by the individual as a result of the violation; or

(II) Ten thousand dollars per violation.

(12) The prevailing party in an action under this section may recover costs and reasonable attorney fees.

Source: L. 2009: Entire section added, (HB 09-1338), ch. 353, p. 1840, § 2, effective July 1. **L. 2010:** (9) amended, (HB 10-1422), ch. 419, p. 2066, § 14, effective August 11.

10-3-1104.7. Genetic testing - legislative declaration - definitions - limitations on disclosure of information - liability. (1) The general assembly hereby finds and determines that recent advances in genetic science have led to improvements in the diagnosis, treatment, and understanding of a significant number of human diseases. The general assembly further declares that:

(a) Genetic information is the unique property of the individual to whom the information pertains;

(b) Any information concerning an individual obtained through the use of genetic techniques may be subject to abuses if disclosed to unauthorized third parties without the willing consent of the individual to whom the information pertains;

(c) To protect individual privacy and to preserve individual autonomy with regard to the individual's genetic information, it is appropriate to limit the use and availability of genetic information;

(d) The intent of this section is to prevent information derived from genetic testing from being used to deny access to group disability insurance or long-term care insurance coverage.

(2) For the purposes of this section:

(a) "Entity" means any entity that provides group disability insurance or long-term care insurance coverage and is subject to the jurisdiction of the commissioner of insurance.

(b) "Genetic testing" means any laboratory test of human DNA, RNA, or chromosomes that is used to identify the presence or absence of alterations in genetic material which are associated with disease or illness. "Genetic testing" includes only such tests as are direct measures of such alterations rather than indirect manifestations thereof.

(3) (a) Information derived from genetic testing shall be confidential and privileged. Any release, for purposes other than diagnosis, treatment, or therapy, of genetic testing information that identifies the person tested with the test results released requires specific written consent by the person tested.

(b) Any entity that receives information derived from genetic testing may not seek, use, or keep the information for any nontherapeutic purpose or for any underwriting purpose connected with the provision of group disability insurance or long-term care insurance coverage.

(4) Notwithstanding the provisions of subsection (3) of this section, in the course of a criminal investigation or a criminal prosecution, and to the extent allowed under the federal or state constitution, any peace officer, district attorney, or assistant attorney general, or a designee thereof, may obtain information derived from genetic testing regarding the identity of any individual who is the subject of the criminal investigation or prosecution for use exclusively in the criminal investigation or prosecution without the consent of the individual being tested.

(5) Notwithstanding the provisions of subsection (3) of this section, any research facility may use the information derived from genetic testing for scientific research purposes so long as the identity of any individual to whom the information pertains is not disclosed to any third party; except that the individual's identity may be disclosed to the individual's physician if the individual consents to such disclosure in writing.

(6) This section does not limit the authority of a court or any party to a parentage proceeding to use information obtained from genetic testing for purposes of determining parentage pursuant to section 13-25-126, C.R.S.

(7) This section does not limit the authority of a court or any party to a proceeding that is subject to the limitations of part 5 of article 64 of title 13, C.R.S., to use information obtained from genetic testing for purposes of determining the cause of damage or injury.

(8) This section does not limit the authority of the state board of parole to require any offender who is involved in a sexual assault to submit to blood tests and to retain the results of such tests on file as authorized under section 17-2-201 (5)(g), C.R.S.

(9) This section does not limit the authority granted the state department of public health and environment, the state board of health, or local departments of health pursuant to section 25-1-122, C.R.S.

(10) Notwithstanding any provision of this section to the contrary, the only requirements that shall apply to an insurer in connection with life insurance or individual disability insurance are as follows:

(a) Except as otherwise specifically authorized or required by another section of state or federal law, an insurer shall not require the performance of or perform a genetic test without first receiving the specific, written, informed consent of the subject of the test who has the capacity to consent or, if the person subject to the test lacks the capacity to consent, of a person authorized by law to consent on behalf of the subject of the test. Written consent shall be in a form prescribed by the commissioner.

(b) The results of a genetic test performed pursuant to this subsection (10) are privileged and confidential and shall not be released to any person except as specifically authorized under applicable state or federal law.

(11) Any violation of this section is an "unfair practice", as defined in section 10-3-1104 (1), and is subject to the provisions of sections 10-3-1106 to 10-3-1113.

(12) Any individual who is injured by an entity's violation of this section may recover in a court of competent jurisdiction the following remedies:

(a) Equitable relief, which may include a retroactive order, directing the entity to provide group disability insurance or long-term care insurance coverage, whichever is appropriate, to the injured individual under the same terms and conditions as would have applied had the violation not occurred; and

(b) The greater of:

(I) An amount equal to any actual damages suffered by the individual as a result of the violation; or

(II) Ten thousand dollars per violation.

(13) The prevailing party in an action under this section may recover costs and reasonable attorney fees.

Source: L. 94: Entire section added, p. 1944, § 1, effective June 2; (9) amended, p. 2614, § 22, effective July 1. **L. 2002:** (10) and (12) amended, p. 990, § 1, effective June 1. **L. 2003:** (12)(b)(I) amended, p. 1982, § 7, effective May 22. **L. 2009:** (1)(d), (2)(a), (3)(b), and (12)(a) amended, (HB 09-1338), ch. 353, p. 1839, § 1, effective July 1.

10-3-1104.8. Domestic abuse discrimination - prohibited. (1) As used in this section, unless the context otherwise requires:

(a) "Domestic abuse" means the occurrence of one or more of the following acts between family members, current or former household members, or persons who are or have been involved in an intimate relationship:

(I) Committing an act of unlawful sexual behavior, as described in part 4 of article 3 of title 18, C.R.S., or otherwise intentionally, knowingly, or recklessly causing or attempting to cause another person, including a minor, bodily injury or physical or psychological harm; or

(II) Knowingly engaging in repeated acts under circumstances that place the person toward which such acts are directed in reasonable fear of bodily injury or physical or psychological harm; or

(III) Subjecting another person to false imprisonment; or

(IV) Intentionally, knowingly, or recklessly causing or attempting to cause damage to property so as to intimidate or attempt to control the behavior of another person.

(b) "Domestic abuse related medical condition" means a medical condition sustained by a victim of domestic abuse that arises in whole or in part out of an act or pattern of domestic abuse.

(c) "Domestic abuse status" means the fact or perception that a person is or has been a victim of domestic abuse, irrespective of whether the person has sustained a domestic abuse related medical condition.

(d) "Victim of domestic abuse" means a person against whom any of the acts specified in paragraph (a) of this subsection (1) has been directed by any of the persons specified in said paragraph (a).

(2) The following are unfair methods of competition and unfair or deceptive acts or practices in the business of insurance by insurers licensed in this state, their employees, or their producers:

(a) Denying, refusing to issue, refusing to renew, refusing to reissue, canceling, or otherwise terminating an insurance policy or restricting coverage on any person solely because of that person's domestic abuse status; or

(b) Adding any surcharge or rating factor to a premium of an insurance policy solely because of an insured's domestic abuse status; or

(c) Directly or indirectly asking an insured or an insurance applicant about that person's domestic abuse status unless related to the provision of appropriate medical or mental health services to an insured as provided by the insurance contract or health maintenance organization, but said information shall not be released without specific, separate authorization from the insured; or

(d) Disclosing or transferring by insurers licensed in this state, their employees, or their producers any information relating to a person's domestic abuse status or a person's domestic abuse related medical condition as it relates to a person's family, household, social, or employment relationship with a victim of domestic abuse, except:

(I) To the extent required in the ordinary course of business and consistent with paragraph (a), (b), or (c) of this subsection (2);

(II) To the extent required for compliance with domestic abuse reporting laws or with an order of a court of competent jurisdiction; or

(III) At the written request of the commissioner for the purpose of determining the insurer's compliance with this section. This paragraph (d) shall not preclude a victim of domestic abuse from obtaining his or her records, including medical records.

(3) An insurer that takes an action that adversely affects an insured or an applicant who is a victim of domestic abuse, shall demonstrate to the applicant or the insured, upon the written request of the insured or applicant, that such action is not based solely upon the domestic abuse status of the insured or the applicant but that the action is based on underwriting criteria related to the condition, property, or claim history of the insured or the applicant and that the decision to take such action was based on sound underwriting and actuarial principles related to actual or anticipated loss experience.

(4) An insurer that complies with this section and acts in good faith shall not be held civilly liable in any cause of action that may be brought because of compliance with this section.

(5) Nothing in this section shall be construed to alter or modify any policy conditions, exclusions, or limitations that are consistent with paragraphs (a), (b), and (c) of subsection (2) of this section and are clearly stated in the contract.

(6) Nothing in this section shall be construed to establish a protected class for victims of domestic abuse.

Source: L. 97: Entire section added, p. 96, § 1, effective January 1, 1998.

10-3-1104.9. Insurers' use of external consumer data and information sources, algorithms, and predictive models - unfair discrimination prohibited - rules - stakeholder process required - investigations - definitions. (1) In addition to the methods and practices prohibited pursuant to section 10-3-1104 (1)(f), an insurer shall not, with regard to any insurance practice:

(a) Unfairly discriminate based on race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression; or

(b) Pursuant to rules adopted by the commissioner, use any external consumer data and information sources, as well as any algorithms or predictive models that use external consumer data and information sources, in a way that unfairly discriminates based on race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression.

(2) (a) The commissioner shall adopt rules for the implementation of this section.

(b) The commissioner shall engage in a stakeholder process prior to the adoption of rules for any type of insurance that includes carriers, producers, consumer representatives, and other interested parties. The commissioner shall hold stakeholder meetings for stakeholders of different types of insurance to ensure sufficient opportunity to consider factors and processes relevant to each type of insurance. The commissioner shall provide notice of stakeholder meetings on the division website, and stakeholder meetings shall be open to the public.

(3) (a) After the stakeholder process described in subsection (2) of this section, the commissioner shall adopt rules for specific types of insurance, by insurance practice, which rules

establish means by which an insurer may demonstrate, to the extent practicable, that it has tested whether its use of external consumer data and information sources, as well as algorithms or predictive models using external consumer data and information sources, unfairly discriminates based on race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression. The rules shall not become effective until January 1, 2023, at the earliest, for any type of insurance, and the commissioner shall consider solvency impacts, if any, to insurers in adopting the rules.

(b) Rules adopted pursuant to this section must require each insurer to:

(I) Provide information to the commissioner concerning the external consumer data and information sources used by the insurer in the development and implementation of algorithms and predictive models for a particular type of insurance and insurance practice;

(II) Provide an explanation of the manner in which the insurer uses external consumer data and information sources, as well as algorithms and predictive models using external consumer data and information sources, for the particular type of insurance and insurance practice;

(III) Establish and maintain a risk management framework or similar processes or procedures that are reasonably designed to determine, to the extent practicable, whether the insurer's use of external consumer data and information sources, as well as algorithms and predictive models using external consumer data and information sources, unfairly discriminates based on race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression;

(IV) Provide an assessment of the results of the risk management framework or similar processes or procedures and actions taken to minimize the risk of unfair discrimination, including ongoing monitoring; and

(V) Provide an attestation by one or more officers that the insurer has implemented the risk management framework or similar processes or procedures appropriately on a continuous basis.

(c) The rules adopted by the commissioner pursuant to this section must include provisions establishing:

(I) A reasonable period of time for insurers to remedy any unfairly discriminatory impact in an algorithm or predictive model; and

(II) The ability of insurers to use external consumer data and information sources, as well as algorithms or predictive models using external consumer data and information sources, that have been previously assessed by the division and found not to be unfairly discriminatory.

(d) Documents, materials, and other information in the possession or control of the division that are obtained by, created by, or disclosed to the commissioner or any other person pursuant to this section or any rules adopted pursuant to this section are recognized as proprietary and containing trade secrets. All such documents, materials, and other information are confidential and privileged; are not subject to disclosure under the "Colorado Open Records Act", part 2 of article 72 of title 24, or other open records, freedom of information, sunshine, or similar law of this state; are not subject to subpoena; and are not subject to discovery or admissible in evidence in any private civil action. However, the commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the

insurer from which the documents, materials, or other information was obtained. The commissioner may make data publicly available in an aggregated or de-identified format in a manner deemed appropriate by the commissioner.

(4) Pursuant to section 10-3-1106, the commissioner may examine and investigate an insurer's use of an external consumer data and information source, algorithm, or predictive model in any insurance practice. Insurers shall cooperate with the commissioner and the division in any examination or investigation under this section.

(5) Repealed.

(6) Notwithstanding any provision of this section to the contrary, this section does not apply to:

(a) Title insurance, as defined in section 10-11-102 (8);

(b) Bonds executed by qualified surety companies pursuant to part 3 of article 4 of this title 10; or

(c) Insurers issuing commercial insurance policies; except that this section does apply to insurers that issue business owners' policies or commercial general liability policies, which business owners' policies or commercial general liability policies have annual premiums of ten thousand dollars or less.

(7) Nothing in this section:

(a) Requires an insurer to collect from an applicant or policyholder the race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression of an individual; or

(b) May be construed to:

(I) Prohibit the use of, or require life, annuity, long-term care, or disability insurers to test, medical, family history, occupational, disability, or behavioral information related to a specific individual, which information, based on actuarially sound principles, has a direct relationship to mortality, morbidity, or longevity risk unless such information is otherwise included in the testing of an algorithm or predictive model that also uses external consumer data and information sources;

(II) Prohibit the use of, or require life, annuity, long-term care, or disability insurers to test, traditional underwriting factors being used for the exclusive purpose of determining insurable interest or eligibility for coverage unless such factors are otherwise included in the testing of an algorithm or predictive model that also uses external consumer data and information sources;

(III) Amend, modify, or supersede section 10-3-1104 (1)(f)(III) or (1)(f)(IV); or

(IV) Prohibit the use of or require the testing of longstanding and well-established common industry practices in settling claims or traditional underwriting practices unless such practices or factors are otherwise included in the testing of an algorithm or predictive model that also uses external consumer data and information sources.

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

(a) "Algorithm" means a computational or machine learning process that informs human decision-making in insurance practices.

(b) (I) "External consumer data and information source" means a data or an information source that is used by an insurer to supplement traditional underwriting or other insurance practices or to establish lifestyle indicators that are used in insurance practices. "External consumer data and information source" includes credit scores, social media habits, locations,

purchasing habits, home ownership, educational attainment, occupation, licensures, civil judgments, and court records.

(II) The commissioner may promulgate rules to further define "external consumer data and information source" for particular lines of insurance and insurance practices.

(c) "Insurance practice" means marketing, underwriting, pricing, utilization management, reimbursement methodologies, and claims management in the transaction of insurance.

(d) "Predictive model" means a process of using mathematical and computational methods that examine current and historical data sets for underlying patterns and calculate the probability of an outcome.

(e) "Unfairly discriminate" and "unfair discrimination" include the use of one or more external consumer data and information sources, as well as algorithms or predictive models using external consumer data and information sources, that have a correlation to race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression, and that use results in a disproportionately negative outcome for such classification or classifications, which negative outcome exceeds the reasonable correlation to the underlying insurance practice, including losses and costs for underwriting.

Source: L. 2021: Entire section added, (SB 21-169), ch. 436, p. 2888, § 2, effective September 7.

Editor's note: Subsection (5)(b) provided for the repeal of subsection (5), effective July 1, 2025. (See L. 2021, p. 2888.)

Cross references: For the legislative declaration in SB 21-169, see section 1 of chapter 436, Session Laws of Colorado 2021.

10-3-1105. Favored agent or insurer - coercion of debtors. (1) No person may:

(a) Require, as a condition precedent to the lending of money, or extension of credit, or to entering into any lease transaction, or any renewal of any of them, that the person to whom such money or credit is extended, or the lessee, or the person whose obligation the creditor is to acquire or finance negotiate any policy or contract of insurance through a particular insurer or group of insurers or agent or broker or group of agents or brokers;

(b) Unreasonably disapprove the insurance policy provided by a borrower or lessee for the protection of the property securing the credit, or lien, or which is the subject of the lease. For the purposes of this paragraph (b), disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required; or

(c) Require directly or indirectly that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge in connection with the handling of any insurance policy required as security for a loan on real estate, or pay a separate charge to substitute the insurance policy of one insurer for that of another. The provisions of this paragraph (c) shall not apply to

the interest which may be charged on premium loans or premium advancements in accordance with the security instrument.

(2) The commissioner may investigate the affairs of any person to whom this section applies to determine whether such person has violated the provisions of this section. If a violation of this section is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of this part 11.

(3) For the purposes of this section, "person" includes any individual, corporation, association, partnership, or other legal entity.

Source: L. 73: R&RE, p. 861, § 1. **C.R.S. 1963:** § 72-14-5. **L. 85:** (1)(a) and (1)(b) amended, p. 302, § 13, effective May 10.

10-3-1106. Power of commissioner. The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by this part 11.

Source: L. 73: R&RE, p. 861, § 1. **C.R.S. 1963:** § 72-14-6.

10-3-1107. Hearings. Whenever the commissioner has reason to believe that any person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice, whether defined or reasonably implied in this part 11, or has violated any other provision of this title or any rule or lawful order of the commissioner and that a proceeding by the commissioner in respect thereto would be to the interest of the public, the commissioner shall proceed as provided in article 4 of title 24, C.R.S. Any final action by the commissioner pursuant to this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 73: R&RE, p. 862, § 1. **C.R.S. 1963:** § 72-14-7. **L. 92:** Entire section amended, p. 1556, § 53, effective May 20. **L. 97:** Entire section amended, p. 1077, § 3, effective July 1.

10-3-1108. Orders. (1) If, after a hearing conducted under section 10-3-1107, the commissioner determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice or has violated any other provision of this title or any rule or lawful order of the commissioner, the commissioner shall reduce the findings to writing and shall issue and cause to be served on such person a copy of such findings and an order requiring such person to cease and desist from engaging in such method of competition, act, practice, or violation, and, except in the case of an act or practice that is not a violation of any specific provision of this title or any specific rule or lawful order of the commissioner, the commissioner may, at his or her discretion, order any one or more of the following:

(a) Payment of a monetary penalty of not more than three thousand dollars for each act or violation but not to exceed an aggregate penalty of thirty thousand dollars, unless such person, being an insurer, knew or reasonably should have known he or she was in violation of this part 11, in which case the penalty shall not be more than thirty thousand dollars for each act or

violation, but not to exceed an aggregate penalty of seven hundred fifty thousand dollars annually;

(b) Suspension or revocation of the person's license if he knew or reasonably should have known he was in violation of the provisions of this part 11; or

(c) Payment of a contractual claim to an insured or beneficiary pursuant to an insurance policy if the commissioner finds that the violation of this part 11 caused the failure to pay the claim, which amount shall be determined by the commissioner at the hearing based on the testimony and evidence presented. This paragraph (c) shall not apply during the pendency of any civil action seeking a declaratory judgment concerning such claims.

(2) Any order issued by the commissioner pursuant to paragraph (c) of subsection (1) of this section may be appealed to the district court, whereupon the matter shall be tried de novo by the district court.

Source: L. 73: R&RE, p. 862, § 1. **C.R.S. 1963:** § 72-14-8. **L. 81:** IP(1) amended, p. 577, § 4, effective June 4. **L. 90:** (1)(c) and (2) added, p. 614, §§ 1, 2, effective April 5. **L. 93:** (1)(a) amended, p. 393, § 2, effective July 1. **L. 94:** IP(1) amended, p. 1628, § 23, effective May 31; IP(1) amended, p. 1946, § 2, effective June 2. **L. 97:** IP(1) amended, p. 1077, § 4, effective July 1; IP(1) amended, p. 98, § 2, effective January 1, 1998. **L. 2008:** (1)(a) amended, p. 2172, § 3, effective August 5.

Editor's note: (1) Amendments to the introductory portion to subsection (1) by Senate Bill 94-058 and Senate Bill 94-206 were harmonized.

(2) Senate Bill 97-072 was superseded by and harmonized with Senate Bill 97-108, because the amendment made in Senate Bill 97-108 has the effect of including the referenced section that was added in Senate Bill 97-072.

10-3-1109. Penalty for violation of cease-and-desist orders. (1) Any person who violates a cease-and-desist order of the commissioner issued under section 10-3-1108, and while such order is in effect, may, after notice and hearing and upon order of the commissioner, be subject, at the discretion of the commissioner, to any one or more of the following:

(a) A monetary penalty of not more than ten thousand dollars for each and every act or violation of an insurer; or a monetary penalty of not more than five hundred dollars for each and every act or violation of an individual;

(b) Suspension or revocation of such person's license.

Source: L. 73: R&RE, p. 862, § 1. **C.R.S. 1963:** § 72-14-9.

10-3-1110. Rules. (1) The commissioner may, after notice and hearing, as provided in article 4 of title 24, C.R.S., promulgate reasonable rules and regulations as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by sections 10-3-1104 and 10-3-1105.

(2) The commissioner may, after notice and hearing, as provided in article 4 of title 24, C.R.S., promulgate rules with respect to the payment of benefits under group and individual contracts of property or casualty coverage, issued by organizations authorized to do business in this state under the provisions of article 4 of this title; except that, to the extent that a provision

of this subsection (2) conflicts with section 10-4-642, as enacted by Senate Bill 04-125, enacted at the second regular session of the sixty-fourth general assembly, the provisions of said section 10-4-642 shall govern. Such rules may establish a penalty payable to the claimant on benefit payments that 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.

(3) (Deleted by amendment, L. 99, p. 1142, § 2, effective January 1, 2000.)

Source: L. 73: R&RE, p. 862, § 1. **C.R.S. 1963:** § 72-14-10. **L. 84:** Entire section amended, p. 331, § 2, effective July 1. **L. 90:** (2) amended, p. 614, § 3, effective April 5. **L. 91:** (2) amended, p. 1909, § 10, effective June 1. **L. 92:** (2) amended, p. 1556, § 54, effective May 20; (2) amended, p. 1724, § 6, effective July 1. **L. 99:** (2) and (3) amended, p. 1142, § 2, effective January 1, 2000. **L. 2003:** (2) amended, p. 1571, § 5, effective July 1. **L. 2004:** (2) amended, p. 894, § 2, effective May 21; (2) amended, p. 1102, § 3, effective July 1.

Editor's note: Amendments to subsection (2) by Senate Bill 92-090 and Senate Bill 92-104 were harmonized.

10-3-1111. Provisions of part 11 additional to existing law. The powers vested in the commissioner by this part 11 shall be additional to any other powers to enforce any monetary or other penalties or forfeitures authorized by law with respect to the methods, acts, and practices declared in this part 11 to be unfair or deceptive.

Source: L. 73: R&RE, p. 862, § 1. **C.R.S. 1963:** § 72-14-11.

10-3-1112. Immunity from prosecution. (1) If any person asks to be excused from attending and testifying or from producing any books, papers, records, correspondence, or other documents at any hearing on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture and, notwithstanding, is directed to give such testimony or produce such evidence, he must comply with such direction; but he shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which he may testify or produce evidence pursuant thereto; and no testimony so given or evidence so produced shall be received against him upon any criminal action, investigation, or proceeding. No such individual so testifying may be exempt from prosecution or punishment for perjury in the first degree committed by him while so testifying, and the testimony or evidence so given or produced shall be admissible against him upon any criminal action, investigation, or proceeding concerning such perjury; nor may he be exempt from the refusal, revocation, or suspension of any license, permission, or authority conferred, or to be conferred, pursuant to the insurance law of this state.

(2) Any such individual may execute, acknowledge, and file in the office of the commissioner a statement expressly waiving such immunity or privilege in respect to any transaction, matter, or thing specified in such statement and thereupon the testimony of such person or such evidence in relation to such transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, grand jury, or otherwise, and if so received or produced such individual shall not be entitled to any immunity or privilege on account of any testimony he may so give or evidence so produced.

Source: L. 73: R&RE, p. 862, § 1. **C.R.S. 1963:** § 72-14-12.

10-3-1113. Information to trier of fact in civil actions. (1) In any civil action for damages founded upon contract, or tort, or both against an insurance company, the trier of fact may be instructed that the insurer owes its insured the duty of good faith and fair dealing, which duty is breached if the insurer delays or denies payment without a reasonable basis for its delay or denial.

(2) Under a policy of liability insurance, the determination of whether the insurer's delay or denial was reasonable shall be based on whether the insurer's delay or denial was negligent.

(3) Under a policy of first-party insurance, the determination of whether the insurer's delay or denial was reasonable shall be based on whether the insurer knew that its delay or denial was unreasonable or whether the insurer recklessly disregarded the fact that its delay or denial was unreasonable.

(4) In determining whether an insurer's delay or denial was reasonable, the jury may be instructed that willful conduct of the kind set forth in section 10-3-1104 (1)(h)(I) to (1)(h)(XIV) is prohibited and may be considered if the delay or denial and the claimed injury, damage, or loss was caused by or contributed to by such prohibited conduct.

Source: L. 87: Entire section added, p. 423, § 1, effective July 1.

10-3-1114. Construction of part 11. Except as provided in sections 10-3-1115 and 10-3-1116, nothing in this part 11 shall be construed to create a private cause of action based on alleged violations of this part 11 or to abrogate any common law contract or tort cause of action.

Source: L. 87: Entire section added, p. 424, § 1, effective July 1. **L. 2008:** Entire section amended, p. 2172, § 4, effective August 5.

10-3-1115. Improper denial of claims - prohibited - definitions - severability. (1) (a) A person engaged in the business of insurance shall not unreasonably delay or deny payment of a claim for benefits owed to or on behalf of any first-party claimant.

(b) For the purposes of this section and section 10-3-1116:

(I) "First-party claimant" means an individual, corporation, association, partnership, or other legal entity asserting an entitlement to benefits owed directly to or on behalf of an insured under an insurance policy. "First-party claimant" includes a public entity that has paid a claim for benefits due to an insurer's unreasonable delay or denial of the claim.

(II) "First-party claimant" does not include:

(A) A nonparticipating provider performing services; or

(B) A person asserting a claim against an insured under a liability policy.

(2) Notwithstanding section 10-3-1113 (3), for the purposes of an action brought pursuant to this section and section 10-3-1116, an insurer's delay or denial was unreasonable if the insurer delayed or denied authorizing payment of a covered benefit without a reasonable basis for that action.

(3) If any provision of this section or its application to any person or circumstance is held illegal, invalid, or unenforceable, no other provisions or applications of this section shall be affected that can be given effect without the illegal, invalid, or unenforceable provision or application, and to this end the provisions of this section are severable.

(4) The general assembly declares that this section is a law regulating insurance.

(5) This section and section 10-3-1116 shall not apply to insurance issued in compliance with the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S.

(6) This section and section 10-3-1116 shall not apply to title insurance issued pursuant to article 11 of this title or to life insurance issued pursuant to article 7 of this title.

(7) The provisions of this section and section 10-3-1116 do not apply to any claim payment that is delayed or denied because of the insurer's participation in the child support enforcement mechanism established in section 26-13-122.7, C.R.S.

Source: L. 2008: Entire section added, p. 2172, § 5, effective August 5. **L. 2016:** (7) added, (HB 16-1165), ch. 157, p. 490, § 1, effective January 1, 2017.

10-3-1116. Remedies for unreasonable delay or denial of benefits - required contract provision - frivolous actions - severability - definition - rules. (1) A first-party claimant as defined in section 10-3-1115 whose claim for payment of benefits has been unreasonably delayed or denied may bring an action in a district court to recover reasonable attorney fees and court costs and two times the covered benefit.

(2) An insurance policy, insurance contract, or plan that is issued in this state and that offers health or disability benefits shall not contain a provision purporting to reserve discretion to the insurer, plan administrator, or claim administrator to interpret the terms of the policy, contract, or plan or to determine eligibility for benefits. If an insurance policy, contract, or plan contains such a provision, the provision is void.

(3) An insurance policy, insurance contract, or plan that is issued in this state shall provide that a person who claims health, life, or disability benefits, whose claim has been denied in whole or in part, and who has exhausted the person's administrative remedies:

(a) Is entitled to have the person's claim reviewed de novo in any court with jurisdiction; and

(b) Is entitled to a trial by jury.

(4) The action authorized in this section is in addition to, and does not limit or affect, other actions available by statute or common law, now or in the future. Damages awarded pursuant to this section shall not be recoverable in any other action or claim.

(5) If the court finds that an action brought pursuant to this section was frivolous as provided in article 17 of title 13, C.R.S., the court shall award costs and attorney fees to the defendant in the action.

(6) If any provision of this section, or of any subsection or portion of this section, or its application to any person or circumstance is held illegal, invalid, or unenforceable, no other

provisions or applications of this section shall be affected that can be given effect without the illegal, invalid, or unenforceable provision or application, and to this end the provisions of this section are severable.

(7) The general assembly declares that this section is a law regulating insurance.

(8) As used in this section, "issued in this state" refers to every health and disability insurance policy, insurance contract, insurance certificate, and insurance agreement existing, offered, issued, delivered, or renewed in the state of Colorado or providing health or disability benefits to a resident or domiciliary of the state of Colorado and every employee benefit plan covering a resident or domiciliary of the state of Colorado, whether or not on behalf of an employer located or domiciled in Colorado, on or after August 5, 2008, notwithstanding any contractual or statutory choice-of-law provision to the contrary.

Source: L. 2008: Entire section added, p. 2173, § 5, effective August 5. **L. 2020:** (2), (3), and (6) amended and (8) added, (SB 20-176), ch. 301, p. 1499, § 2, effective September 14.

Cross references: For the legislative declaration in SB 20-176, see section 1 of chapter 301, Session Laws of Colorado 2020.

10-3-1117. Required disclosures - liability - definition. (1) Not more than thirty calendar days after receiving a written request from an insured party, an insurer that issues a commercial automobile or personal automobile policy of insurance for delivery in this state shall provide to the insured party a copy of the complete policy of insurance, including any endorsements.

(2) (a) Each insurer that provides or may provide commercial automobile or personal automobile liability insurance coverage to pay all or a portion of a pending or prospective claim shall provide to the claimant or the claimant's attorney via mail, facsimile, or electronic delivery, within thirty calendar days after receiving a written request from the claimant or the claimant's attorney, which request is sent to the insurer's registered agent, a statement setting forth the following information with regard to each known policy of insurance of the named insured, including excess or umbrella insurance, that is or may be relevant to the claim:

(I) The name of the insurer;

(II) The name of each insured party, as the name appears on the declarations page of the policy;

(III) The limits of the liability coverage; and

(IV) A copy of the policy.

(b) An insured party, upon written request of a claimant or a claimant's attorney, shall disclose to the claimant or claimant's attorney the name and coverage of each known insurer of the insured party.

(3) An insurer that violates this section is liable to the requesting claimant for damages in an amount of one hundred dollars per day, beginning on and including the thirty-first day following the receipt of the claimant's written request. The penalty accrues until the insurer provides the information required by this section. An insurer that fails to make a disclosure required by this section is also responsible for attorney fees and costs incurred by a claimant in enforcing the penalty.

(4) The claimant and any attorney of the claimant shall not disclose to any party the information described in subsection (2)(a) of this section; except that the claimant and an attorney of the claimant may discuss the information with the claimant's insurer.

(5) As used in this section, unless the context otherwise requires, "claimant" means a person that has provided notice to an insurer of a potential claim.

Source: L. 2019: Entire section added, (HB 19-1283), ch. 250, p. 2427, § 2, effective January 1, 2020.

10-3-1118. Failure-to-cooperate defense. (1) To plead or prove a failure-to-cooperate defense in an action concerning an insurance policy providing first-party benefits or coverage, each of the following conditions must be met before the defense is asserted in a court of law or an arbitration:

(a) The insurer has submitted a written request to the insured or the insured's representative for the information the insurer seeks via:

(I) Electronic means if the insured or the insured's representative has consented to receive electronic documents from the insurer; or

(II) Certified mail;

(b) The information is not available to the insurer without the assistance of the insured;

(c) The written request provides the insured sixty days to respond;

(d) The written request is for information a reasonable person would determine the insurer needs to adjust the claim filed by the insured or to prevent fraud; and

(e) The insurer gives the insured an opportunity to cure, which must:

(I) Include the furnishing of written notice to the insured of the alleged failure to cooperate, describing with particularity the alleged failure, within sixty days after the alleged failure; and

(II) Allow the insured sixty days after receipt of the written notice to cure the alleged failure to cooperate.

(2) A failure-to-cooperate defense acts as a defense to the portion of the claim materially and substantially prejudiced to the extent the insurer could not evaluate or pay that portion of the claim.

(3) The existence of a duty to cooperate in a policy does not relieve the insurer of its duty to investigate or to comply with section 10-3-1104.

(4) Any language in a first-party policy that conflicts with this section is void as against the public policy of Colorado.

(5) An insurer is not liable for a claim in a civil action based upon a bad-faith breach of contract under common law or under sections 10-3-1115 and 10-3-1116 because the insurer solely provides the insured with the required amount of time:

(a) To respond to the insurer's written request as specified under subsection (1)(c) of this section; and

(b) To cure the alleged failure to cooperate as specified under subsection (1)(e) of this section.

Source: L. 2020: Entire section added, (HB 20-1290), ch. 229, p. 1116, § 1, effective September 14.

10-3-1119. Policy documents - language consistent with advertisement for product - definitions. (Repealed)

Source: L. 2023: Entire section added, (HB 23-1004), ch. 64, p. 229, § 2, effective January 1, 2024. **L. 2024:** Entire section repealed, (HB 24-1440), ch. 320, p. 2142, § 4, effective May 31.

PART 12

SYSTEMS FOR HOLDING AND TRANSFERRING SECURITIES

10-3-1201. Legislative declaration. The purpose of section 10-3-210 (2) and this part 12 is to authorize domestic insurance companies to utilize modern systems for holding and transferring securities without physical delivery of securities certificates, subject to appropriate regulations of the commissioner.

Source: L. 83: Entire part added, p. 451, § 2, effective May 3.

10-3-1202. Definitions. As used in this part 12, unless the context otherwise requires:

(1) "Clearing corporation" has the meaning ascribed to it in section 4-8-102 (a)(5), C.R.S.; except that, with respect to a security issued by an institution organized or existing under the laws of any foreign country or a security used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "clearing corporation" includes a corporation which is organized or existing under the laws of any foreign country and which is legally qualified under such laws to effect transactions in securities by computerized book-entry.

(2) "Direct participant" means a bank or trust company or other institution which maintains an account in its name in a clearing corporation and through which an insurance company participates in a clearing corporation.

(3) "Federal reserve book-entry system" means the computerized system sponsored by the United States department of the treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and such agencies and instrumentalities, respectively, in federal reserve banks through banks which are members of the federal reserve system or which otherwise have access to such computerized system.

(4) "Member bank" means a national bank, state bank, or trust company which is a member of the federal reserve system and through which an insurance company participates in the federal reserve book-entry system.

(5) "Security" has any of the meanings specified in section 4-8-102 (a)(15), C.R.S.

Source: L. 83: Entire part added, p. 451, § 2, effective May 3. **L. 96:** (1) and (5) amended, p. 245, § 22, effective July 1.

10-3-1203. Book-entry system. (1) Notwithstanding any provision of law, a domestic insurance company may deposit or arrange for the deposit of securities held in or purchased for

its general account and its separate accounts in a clearing corporation or the federal reserve book-entry system. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any member bank through which an insurance company holds securities in the federal reserve book-entry system and the records of any custodian banks through which an insurance company holds securities in a clearing corporation shall, at all times, show that such securities are held for such insurance company and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation or in the federal reserve book-entry system without, in either case, physical delivery of certificates representing such securities.

(2) The commissioner is authorized to promulgate rules and regulations governing the deposit by insurance companies of securities with clearing corporations and in the federal reserve book-entry system.

Source: L. 83: Entire part added, p. 452, § 2, effective May 3.

PART 13

MODEL QUALITY REPLACEMENT PARTS ACT

10-3-1301. Short title. This part 13 shall be known and may be cited as the "Model Quality Replacement Parts Act".

Source: L. 89: Entire part added, p. 450, § 1, effective July 1.

10-3-1302. Legislative declaration. The general assembly declares that the purpose of this article is to recognize the use of replacement automobile crash parts by requiring disclosure when any use is proposed of a nonoriginal equipment replacement crash part, and by requiring that the manufacturer of any such replacement crash part be adequately identified.

Source: L. 89: Entire part added, p. 450, § 1, effective July 1.

10-3-1303. Definitions. As used in this part 13, unless the context otherwise requires:

(1) "Insurer" means every person engaged as principal, indemnitor, surety, or contractor in the business of making contracts of insurance, and any person authorized to represent an insurer with respect to a claim.

(2) "Nonoriginal equipment replacement crash part" means a replacement crash part which is not supplied by the manufacturer of the motor vehicle on which the part is used.

(3) "Replacement crash part" means a replacement for any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels.

Source: L. 89: Entire part added, p. 450, § 1, effective July 1.

10-3-1304. Identification of parts. Any nonoriginal equipment replacement crash part supplied for use in this state shall have the name or trademark of the manufacturer affixed to or inscribed on it. Such name or trademark shall be placed so as to be visible after installation of the part whenever practicable.

Source: L. 89: Entire part added, p. 451, § 1, effective July 1.

10-3-1305. Disclosure. No insurer shall specify the use of nonoriginal equipment replacement crash parts in the repair of an insured's motor vehicle without disclosing the intended use of such parts to the insured. In all instances where nonoriginal equipment replacement crash parts are intended for use by an insurer, the written estimate shall clearly identify each such part as being a nonoriginal equipment replacement crash part, and a disclosure document containing the following information in ten-point type or larger type shall appear on or be attached to the insured's copy of the estimate: "This estimate has been prepared based on the use of one or more crash parts supplied by a source other than the manufacturer of your motor vehicle. Warranties, if any, applicable to these replacement crash parts are provided by the parts manufacturer or distributor rather than by the manufacturer of your vehicle."

Source: L. 89: Entire part added, p. 451, § 1, effective July 1.

10-3-1306. Unfair and deceptive acts. A violation of or noncompliance with any provision of this part 13 shall be an unfair method of competition and unfair or deceptive act or practice in the business of insurance subject to the provisions of part 11 of this article.

Source: L. 89: Entire part added, p. 451, § 1, effective July 1.

10-3-1307. Liability. Nothing in this part 13 shall affect either rights, defenses, or liabilities of parties otherwise available at law regarding damages or injuries arising from the use of replacement crash parts.

Source: L. 89: Entire part added, p. 451, § 1, effective July 1.

PART 14

MODEL RISK RETENTION ACT

10-3-1401. Short title. This part 14 shall be known and may be cited as the "Model Risk Retention Act".

Source: L. 91: Entire part added, p. 1248, § 10, effective July 1.

10-3-1402. Purpose. The purpose of this part 14 is to authorize the commissioner to regulate the formation or operation, or both, of risk retention groups and purchasing groups in

this state formed pursuant to the provisions of the federal "Liability Risk Retention Act of 1986", to the extent permitted by such federal law.

Source: L. 91: Entire part added, p. 1248, § 10, effective July 1.

Cross references: For the federal "Liability Risk Retention Act of 1986", see 15 U.S.C. § 3901 et seq.

10-3-1403. Authority of commissioner. The commissioner may establish, and from time to time amend, such regulations as are necessary to enable the commissioner to regulate risk retention groups and purchasing groups in this state to the extent permitted by the federal "Liability Risk Retention Act of 1986" and pursuant to the provisions of the laws of the state of Colorado.

Source: L. 91: Entire part added, p. 1248, § 10, effective July 1.

Cross references: For the "Liability Risk Retention Act of 1986", see 15 U.S.C. § 3901 et seq.

PART 15

OWN RISK AND SOLVENCY ASSESSMENT (ORSA)

10-3-1501. Purpose and scope - applicability - legislative declaration. (1) The purpose of this part 15 is to provide the requirements for maintaining a risk management framework and completing an own risk and solvency assessment (ORSA) and provide guidance and instructions for filing an ORSA summary report with the commissioner.

(2) The requirements of this part 15 apply to all insurers domiciled in this state unless exempt pursuant to section 10-3-1506.

(3) The general assembly finds and declares that the ORSA summary report will contain confidential and sensitive information related to an insurer's or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. It is the intent of the general assembly that the ORSA summary report be a confidential document filed with the commissioner, be shared only as stated in this part 15 and to assist the commissioner in the performance of his or her duties, and not be subject to public disclosure.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 73, § 2, effective March 18.

10-3-1502. Definitions. As used in this part 15, unless the context otherwise requires:

(1) "Insurance group" means, for the purpose of conducting an ORSA, those insurers and affiliates included within an insurance holding company system as defined in section 10-3-801 (5).

(2) "Insurer" has the same meaning as set forth in section 10-3-801 (6) and includes any political subdivision of the state created pursuant to article 45 of title 8, C.R.S.

(3) "NAIC" or "National Association of Insurance Commissioners" means the organization of insurance regulators from the fifty states, the District of Columbia, and the five United States territories.

(4) "ORSA guidance manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the NAIC and as amended from time to time. A change in the ORSA guidance manual is effective on the January 1 following the calendar year in which the change is adopted by the NAIC.

(5) "ORSA summary report" means a confidential, high-level summary of an insurer's or insurance group's ORSA.

(6) "Own risk and solvency assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer's or insurance group's current business plan and the sufficiency of capital resources to support those risks.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 73, § 2, effective March 18. **L. 2023:** (3) amended, (HB 23-1301), ch. 303, p. 1817, § 8, effective August 7.

10-3-1503. Risk management framework. An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 74, § 2, effective March 18.

10-3-1504. ORSA requirement. Subject to section 10-3-1506, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA guidance manual. The ORSA must be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 74, § 2, effective March 18.

10-3-1505. ORSA summary report. (1) Upon the commissioner's request, and no more than once each year, an insurer shall submit to the commissioner an ORSA summary report or any combination of reports that together contain the information described in the ORSA guidance manual, applicable to the insurer or the insurance group of which it is a member or to both the insurer and insurance group. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report required by this section if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the financial analysis handbook adopted by the NAIC.

(2) The report shall include a signature of the insurer's or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process, attesting to the best of his or her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee of the board of directors.

(3) An insurer may comply with subsection (1) of this section by providing the most recent and substantially similar report provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA guidance manual. Any report in a language other than English must be accompanied by a translation of that report into the English language.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 74, § 2, effective March 18.

10-3-1506. Exemption. (1) An insurer is exempt from the requirements of this part 15 if:

(a) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the federal crop insurance corporation and national flood insurance program, less than five hundred million dollars; and

(b) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the federal crop insurance corporation and national flood insurance program, less than one billion dollars.

(2) If an insurer qualifies for exemption under paragraph (a) of subsection (1) of this section, but the insurance group of which the insurer is a member does not qualify for exemption under paragraph (b) of subsection (1) of this section, then the ORSA summary report required under section 10-3-1505 must include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA summary report for any combination of insurers if any combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption under paragraph (a) of subsection (1) of this section, but the insurance group of which it is a member qualifies for exemption under paragraph (b) of subsection (1) of this section, then the only ORSA summary report required under section 10-3-1505 is the report applicable to that insurer.

(4) An insurer that does not qualify for exemption under subsection (1) of this section may apply to the commissioner for a waiver from the requirements of this part 15 based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(5) Notwithstanding the exemptions provided in this section:

(a) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report based on unique circumstances including the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests;

(b) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report if the insurer has risk-based capital for a company action level event as set forth in the applicable rules promulgated by the commissioner relating to insurers' risk-based capital, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in the applicable rules promulgated by the commissioner to define standards and the commissioner's authority for companies deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(6) If an insurer that qualifies for an exemption under subsection (1) of this section subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer has one year after the year the threshold is exceeded to comply with the requirements of this part 15.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 75, § 2, effective March 18.

10-3-1507. Contents of ORSA summary report. (1) The ORSA summary report must be prepared to be consistent with the ORSA guidance manual, subject to the requirements of subsection (2) of this section. Documentation and supporting information must be maintained and made available upon examination or upon request of the commissioner.

(2) The review of the ORSA summary report and any additional requests for information must be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 76, § 2, effective March 18.

10-3-1508. Confidentiality. (1) Documents, materials, or other information, including the ORSA summary report, in the possession or control of the division of insurance that are obtained by, created by, or disclosed to the commissioner or any other person under this part 15, are recognized by this state as being proprietary and containing trade secrets. All documents, materials, or other information, including the ORSA summary report, are confidential by law and privileged; are not subject to the "Colorado Open Records Act", part 2 of article 72 of title 24, C.R.S., or other open records, freedom of information, sunshine, or other similar law of this state; are not subject to subpoena; and are not subject to discovery or admissible in evidence in any private civil action. However, the commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

(2) Neither the commissioner nor any person who received documents, materials, or other ORSA-related information, through examination or otherwise, while acting under the

authority of the commissioner or with whom such documents, materials, or other information are shared pursuant to this part 15 is permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the commissioner's regulatory duties, the commissioner:

(a) May, upon request, share documents, materials, or other ORSA-related information, including the confidential and privileged documents, materials, or information subject to subsection (1) of this section, including proprietary and trade-secret documents and materials, with other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in section 10-3-807, with the NAIC and with any third-party consultants designated by the commissioner, if the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality; and

(b) May receive documents, materials, or other ORSA-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in section 10-3-807, and from the NAIC, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information;

(c) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this part 15, consistent with this subsection (3), which agreement must:

(I) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this part 15, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement must provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(II) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this part 15 remains with the commissioner and that the NAIC's or third-party consultant's use of the information is subject to the direction of the commissioner;

(III) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this part 15 in a permanent database after the underlying analysis is completed;

(IV) Require prompt notice be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this part 15 is subject to a request or subpoena to the NAIC or third-party consultant for disclosure or production;

(V) Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or third-party consultant pursuant to this part 15; and

(VI) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(4) The sharing of information and documents by the commissioner under this part 15 does not constitute a delegation of regulatory authority or rule-making, and the commissioner is solely responsible for the administration, execution, and enforcement of this part 15.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials, or other ORSA-related information may occur as a result of disclosure of such ORSA-related information or documents to the commissioner under this section or as a result of sharing as authorized in this part 15.

(6) Documents, materials, or other information in the possession or control of the NAIC or a third-party consultant under this part 15 is confidential by law and privileged; is not subject to the "Colorado Open Records Act", part 2 of article 72 of title 24, C.R.S., or other open records, freedom of information, sunshine, or other similar law of this state; is not subject to subpoena; and is not subject to discovery or admissible in evidence in any private civil action.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 76, § 2, effective March 18.

10-3-1509. Sanctions. Any insurer failing, without just cause, to timely file the ORSA summary report as required in this part 15 shall, after notice and hearing, pay a penalty of two hundred dollars for each day's delay. The maximum penalty under this section is twenty-five thousand dollars. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 78, § 2, effective March 18.

10-3-1510. Rules. The commissioner may, upon notice and opportunity for all interested persons to be heard, issue rules and orders as are necessary to carry out this part 15.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 78, § 2, effective March 18.

10-3-1511. Effective date. The requirements of this part 15 are effective beginning with calendar year 2017. The first required filing of the ORSA summary report is in 2017 as specified in section 10-3-1505. An insurer that has maintained a risk management framework consistent with the requirements of this part 15 in calendar year 2016 may, but is not required to, file its ORSA summary report in 2016, and such report will be confidential as specified in section 10-3-1508.

Source: L. 2016: Entire part added, (SB 16-029), ch. 32, p. 78, § 2, effective March 18.

PART 16

CORPORATE GOVERNANCE ANNUAL DISCLOSURES

10-3-1601. Purpose and scope - applicability - legislative declaration. (1) The purpose of this part 16 is to:

(a) Provide the commissioner a summary of each insurer's and insurance group's corporate governance structure, policies, and practices to permit the commissioner to gain and maintain an understanding of each insurer's and insurance group's corporate governance framework;

(b) Outline the requirements for submitting a corporate governance annual disclosure to the commissioner; and

(c) Provide for the confidential treatment of each insurer's and insurance group's corporate governance annual disclosure and related information, which may contain confidential and sensitive information related to the insurer's or insurance group's internal operations, including proprietary and trade secret information the public disclosure of which could potentially cause competitive harm or disadvantage to the insurer or insurance group.

(2) (a) Nothing in this part 16 may be construed to prescribe or impose corporate governance standards or internal procedures beyond those standards and procedures that are required under applicable Colorado corporate law.

(b) Notwithstanding subsection (2)(a) of this section, nothing in this part 16 may be construed to limit the commissioner's authority or the rights or obligations of third parties under part 2 of article 1 of this title 10.

(3) The requirements of this part 16 apply to all insurers domiciled in this state.

Source: L. 2019: Entire part added, (HB 19-1291), ch. 188, p. 2084, § 1, effective August 2.

10-3-1602. Definitions. As used in this part 16, unless the context otherwise requires:

(1) "Corporate governance annual disclosure" or "CGAD" means a confidential report filed by an insurer or an insurance group in accordance with the requirements of this part 16.

(2) "Insurance group" means those insurers and affiliates that are included within an insurance holding company system, as defined in section 10-3-801 (5).

(3) "Insurer" has the meaning set forth in section 10-3-801 (6); except that "insurer" does not include an agency, authority, or instrumentality of the United States or its possessions and territories, the commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(4) "NAIC" means the National Association of Insurance Commissioners.

(5) "ORSA summary report" has the meaning set forth in section 10-3-1502 (5).

Source: L. 2019: Entire part added, (HB 19-1291), ch. 188, p. 2085, § 1, effective August 2.

10-3-1603. Disclosure requirement. (1) On June 1, 2020, and on June 1 of each year thereafter, an insurer, or the insurance group of which the insurer is a member, shall submit to the commissioner a CGAD that contains the information described in section 10-3-1604 and in subsection (2) of this section. Notwithstanding any request from the commissioner made pursuant to subsection (3) of this section, if an insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of the lead state for

the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent financial analysis handbook adopted by the NAIC.

(2) The CGAD must include the signature of the insurer or insurance group's chief executive officer or corporate secretary attesting that, to the best of that individual's belief and knowledge:

(a) The insurer or insurance group has implemented the corporate governance practices; and

(b) A copy of the disclosure has been provided to the insurer or insurance group's board of directors or the appropriate committee thereof.

(3) An insurer or insurance group that is not required to submit a CGAD under this section shall do so at the commissioner's request.

(4) (a) For purposes of completing a CGAD, an insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, at an intermediate holding company level, or at the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. Each insurer and insurance group is encouraged to make its CGAD disclosures at:

(I) The level at which the insurer's or insurance group's risk appetite is determined;

(II) The level at which the earnings, capital, liquidity, operations, and reputation of the insurer or insurance group are overseen collectively and at which the supervision of these factors is coordinated and exercised; or

(III) The level at which legal liability for failure of general corporate governance duties would be placed.

(b) If an insurer or insurance group makes its CGAD disclosures at a level described in subsection (4)(a) of this section, the insurer or insurance group shall include in the CGAD an indication of which level and an explanation of any subsequent change in the level.

(5) The commissioner's review of the CGAD and any additional requests for information shall be made through the lead state of the insurance group, as determined by the procedures within the most recent financial analysis handbook adopted by the NAIC.

(6) Insurers and insurance groups that provide to the commissioner other documents that include information substantially similar to the information required by this part 16, including proxy statements filed pursuant to section 10-3-804 and other state or federal filings provided to the division, are not required to duplicate that information in the CGAD but shall include in the CGAD cross references indicating which document or documents include the information.

Source: L. 2019: Entire part added, (HB 19-1291), ch. 188, p. 2085, § 1, effective August 2.

10-3-1604. Contents of corporate governance annual disclosure - rules. (1) In responding to a request for CGAD-related information, an insurer or insurance group may exercise its discretion so long as its CGAD provides the commissioner sufficient information to understand the insurer's or insurance group's corporate governance structure, policies, and practices. The commissioner may request that an insurer or insurance group provide additional information for this purpose.

(2) Notwithstanding subsection (1) of this section, each insurer and insurance group shall prepare each CGAD in compliance with this part 16 and with requirements established

pursuant to rules promulgated by the commissioner pursuant to section 10-3-1608. Each insurer and insurance group that submits a CGAD shall maintain documentation and supporting information and make such documentation and supporting information available upon request of the commissioner.

Source: L. 2019: Entire part added, (HB 19-1291), ch. 188, p. 2086, § 1, effective August 2.

10-3-1605. Confidentiality. (1) Documents, materials, and other information, including a CGAD, in the possession or control of the division that are obtained by, created by, or disclosed to the commissioner or any other person under this part 16 are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials, and other information are confidential by law and privileged, not subject to the "Colorado Open Records Act", part 2 of article 72 of title 24; not subject to subpoena; and not subject to discovery or admissible as evidence in any private civil action. However, the commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer or insurance group. Nothing in this section may be construed to require the written consent of an insurer or insurance group before the commissioner may share or receive confidential documents, materials, or other CGAD-related information pursuant to subsection (3) of this section.

(2) Neither the commissioner nor any person who received documents, materials, or other CGAD-related information through examination or otherwise while acting under the authority of the commissioner, or with whom such documents, materials, or other information are shared pursuant to this part 16, may be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (1) of this section.

(3) In order to perform the commissioner's regulatory duties, the commissioner:

(a) May, upon request and subject to subsection (1) of this section, share documents, materials, and other CGAD-related information, including confidential and privileged documents, materials, and information and proprietary and trade secret documents and materials, with other state, federal, and international financial regulatory agencies, including members of any supervisory college, as described in section 10-3-807; the NAIC; and third-party consultants pursuant to section 10-3-1606 so long as the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(b) May receive documents, materials, and other CGAD-related information, including confidential and privileged documents, materials, and information and proprietary and trade secret documents and materials, from regulatory officials of state, federal, and international financial regulatory agencies, including members of any supervisory college as described in section 10-3-807 and the NAIC; and

(c) Shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(4) The sharing of information and documents by the commissioner pursuant to this part 16 does not constitute a delegation of regulatory authority or rule-making, and the commissioner is solely responsible for the administration, execution, and enforcement of this part 16.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials, or other CGAD-related information occurs as a result of disclosure of the documents, materials, or information to the commissioner under this section or as a result of sharing as authorized in this part 16.

Source: L. 2019: Entire part added, (HB 19-1291), ch. 188, p. 2087, § 1, effective August 2.

10-3-1606. Retention of third-party consultants - information sharing. (1) The commissioner may retain, at the expense of an insurer or insurance group, one or more third-party consultants, including attorneys, actuaries, accountants, and other experts who are not otherwise members of the commissioner's staff, as may be reasonably necessary to assist the commissioner in reviewing the insurer's or insurance group's CGAD and related information or the insurer's or insurance group's compliance with this part 16.

(2) Any persons retained pursuant to subsection (1) of this section shall act under the direction and control of the commissioner and in a purely advisory capacity.

(3) The NAIC and third-party consultants are subject to the same confidentiality standards and requirements established for the commissioner in section 10-3-1605 and elsewhere in this part 16.

(4) As part of the retention process, a third-party consultant shall verify to the commissioner that the consultant has no conflict of interest, has internal procedures in place to prevent conflicts of interest, and will comply with the confidentiality standards and requirements of this part 16. A third-party consultant shall also provide such verification to the insurer or insurance group whose CGAD the third-party consultant will review.

(5) A written agreement with the NAIC or with a third-party consultant that governs sharing and use of information provided pursuant to this part 16 must contain the following provisions and must expressly require the written consent of the insurer or insurance group before any such information may be publicly disclosed:

(a) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information that is shared with the NAIC or with a third-party consultant pursuant to this part 16;

(b) Procedures and protocols for sharing by the NAIC only with other state regulators from states in which an insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(c) A provision specifying that ownership of the CGAD-related information shared with the NAIC or with a third-party consultant remains with the division, and the NAIC's or third-party consultant's use of the information is subject to the direction of the commissioner;

(d) A provision that prohibits the NAIC or third-party consultant from storing the information shared pursuant to this part 16 in a permanent database after the underlying analysis is completed;

(e) A provision requiring the NAIC or third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

(f) A provision stating that the NAIC or third-party consultant consents to intervention by an insurer or insurance group in any judicial or administrative action in which the NAIC or third-party consultant may be required to disclose confidential information about the insurer or insurance group.

Source: L. 2019: Entire part added, (HB 19-1291), ch. 188, p. 2088, § 1, effective August 2.

10-3-1607. Sanctions. Any insurer or insurance group that fails, without just cause, to timely file a CGAD as required in this part 16 shall pay, after notice and a hearing, a penalty of two hundred dollars for each day's delay. The maximum penalty under this section is twenty-five thousand dollars. The commissioner may reduce the penalty if the insurer or insurance group demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer or insurance group.

Source: L. 2019: Entire part added, (HB 19-1291), ch. 188, p. 2089, § 1, effective August 2.

10-3-1608. Rules. The commissioner shall, upon notice and opportunity for all interested persons to be heard, issue rules and orders to carry out this part 16.

Source: L. 2019: Entire part added, (HB 19-1291), ch. 188, p. 2089, § 1, effective August 2.

PART 17

DOMESTIC STOCK INSURER DIVISION

10-3-1701. Definitions. As used in this part 17, unless the context otherwise requires:

(1) "Asset" means property, whether real, personal, mixed, tangible, or intangible, and any right or interest in the property, including all rights under a contract or other agreement.

(2) "Capital" means the capital stock component of a statutory surplus, as defined in the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual, version effective January 1, 2001, as revised.

(3) (a) "Contract holder" means the owner of an annuity contract.

(b) "Contract holder" does not mean a certificate holder of a group annuity contract or any other covered person thereunder.

(4) "Divide" or "division" means the act by operation of law by which a domestic stock insurer splits into two or more resulting domestic stock insurers in accordance with a plan of division and this part 17.

(5) "Dividing insurer" means a domestic stock insurer that approves a plan of division.

(6) "Domestic stock insurer" means an insurance company that has capital stock and is incorporated under the laws of this state.

(7) "Liability" means any liability or obligation arising in any manner.

(8) "Plan of division" means a plan of division that is approved by a dividing insurer pursuant to section 10-3-1707.

(9) (a) "Policyholder" means the owner of an insurance policy.

(b) "Policyholder" does not mean a certificate holder of a group insurance policy or any other covered person thereunder.

(10) "Resulting insurer" means a dividing domestic stock insurer that survives a division or a new domestic stock insurer that is created by a division.

(11) "Shareholder" means:

(a) A person in whose name shares are registered in the records of a corporation; or

(b) The beneficial owner of shares to the extent of the rights granted by a nominee certificate on file with a corporation.

(12) "Surplus" means the total statutory surplus minus capital, calculated in accordance with the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual, version effective January 1, 2001, as revised.

(13) "Transfer" means an assignment; assumption; conveyance; sale; lease; encumbrance, including a mortgage or security interest; gift; or transfer by operation of law.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 843, § 1, effective September 7.

10-3-1702. Plan of division - general requirements. (1) A domestic stock insurer may, in accordance with this part 17, divide into two or more resulting insurers pursuant to a plan of division. A domestic stock insurer's plan of division must include:

(a) The name of the domestic stock insurer seeking to divide;

(b) The name of each resulting insurer created by the proposed division and, for each resulting insurer, a copy of the resulting insurer's:

(I) Proposed articles of incorporation; and

(II) Proposed bylaws;

(c) The manner of allocating assets and liabilities, including policy liabilities, between or among all resulting insurers;

(d) The manner of distributing shares in the resulting insurers to the dividing insurer or the dividing insurer's shareholders;

(e) A reasonable description of all liabilities and all assets that the dividing insurer proposes to allocate to each resulting insurer, including the manner by which the dividing insurer proposes to allocate all reinsurance contracts;

(f) All terms and conditions required by the laws of this state and the articles of incorporation and bylaws of the dividing insurer; and

(g) All other terms and conditions required by the division.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 844, § 1, effective September 7.

10-3-1703. Plan of division - dividing insurer to survive division. (1) If a dividing insurer will survive a division, the plan of division must include, in addition to the requirements described in section 10-3-1702:

(a) All proposed amendments to the dividing insurer's articles of incorporation and bylaws;

(b) If the dividing insurer intends to cancel some but not all shares in the dividing insurer, the manner in which the dividing insurer intends to cancel the shares; and

(c) If the dividing insurer intends to convert some but not all shares in the dividing insurer into shares, securities, obligations, rights to acquire shares or securities, cash, property, or any combination thereof, a statement disclosing the manner in which the dividing insurer intends to convert the shares.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 845, § 1, effective September 7.

10-3-1704. Plan of division - dividing insurer to not survive division. If a dividing insurer will not survive a division, the plan of division must include, in addition to the requirements described in section 10-3-1702, the manner in which the dividing insurer will cancel or convert shares in the dividing insurer into shares, securities, obligations, rights to acquire shares or securities, cash, property, or any combination thereof.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 845, § 1, effective September 7.

10-3-1705. Amending plan of division. (1) A dividing insurer may amend the dividing insurer's plan of division in accordance with any procedures set forth in the plan of division or, if procedures are not set forth in the plan of division, in a manner determined by the board of directors of the dividing insurer. A shareholder that is entitled to vote on or consent to approval of the plan of division is entitled to vote on or consent to an amendment of the plan of division that will affect:

(a) The amount or kind of shares, securities, obligations, rights to acquire shares or securities, cash, property, or any combination thereof to be received by any of the shareholders of the dividing insurer under the plan of division;

(b) The articles of incorporation or bylaws of any resulting insurer that become effective when the division becomes effective, except for changes that do not require approval of the shareholders of the resulting insurer under its articles of incorporation or bylaws; or

(c) Any other terms or conditions of the plan of division that effect a change that may adversely affect the shareholders in any material respect.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 845, § 1, effective September 7.

10-3-1706. Abandoning plan of division. (1) A dividing insurer may abandon its plan of division only as follows:

(a) After the dividing insurer has approved the plan of division without any action by the shareholders and in accordance with any procedures set forth in the plan of division, or if procedures are not set forth in the plan of division, in a manner determined by the board of directors of the dividing insurer; or

(b) After the dividing insurer has filed a certificate of division with the commissioner pursuant to section 10-3-1710, the dividing insurer may file a signed certificate of abandonment with the commissioner. The certificate of abandonment is effective on the date it is filed with the commissioner.

(2) A dividing insurer shall not abandon its plan of division after the plan of division becomes effective.

(3) If a dividing insurer elects to abandon its plan of division after the plan has been filed with the commissioner but before it becomes effective, the dividing insurer shall notify the commissioner.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 846, § 1, effective September 7.

10-3-1707. Approval of plan of division - articles of incorporation and bylaws. (1) A dividing insurer shall not file a plan of division with the commissioner until the plan of division has been approved in accordance with all provisions of the dividing insurer's articles of incorporation and bylaws. If the dividing insurer's articles of incorporation and bylaws do not provide for approval of a plan of division, the dividing insurer shall not file the plan of division with the commissioner unless the plan of division has been approved in accordance with all provisions of the dividing insurer's articles of incorporation and bylaws that provide for approval of a merger.

(2) If a provision of a dividing insurer's articles of incorporation or bylaws adopted before September 7, 2021, requires that a specific number or percentage of the board of directors or shareholders propose or adopt a plan of merger or impose other procedures for the proposal or adoption of a plan of merger, the dividing insurer shall adhere to the provision in proposing or adopting a plan of division. If any such provision of the articles of incorporation or bylaws is amended on or after September 7, 2021, the provision applies to a division after September 7, 2021, only in accordance with its express terms.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 846, § 1, effective September 7.

10-3-1708. Commissioner approval of plan of division. (1) After a dividing insurer approves a plan of division pursuant to section 10-3-1707, the dividing insurer shall file the plan of division with the commissioner. Within ten business days after filing the plan of division with the commissioner, the dividing insurer shall provide notice of the filing to each reinsurer that is a party to a reinsurance contract allocated in the plan of division.

(2) A division may not become effective until it is approved by the commissioner in accordance with this section and a certificate of division is filed in accordance with section 10-3-1710.

(3) Before approving a plan of division, the commissioner shall:

(a) Hold a public hearing in accordance with section 24-4-105, except to the extent that the procedures set forth in section 24-4-105 conflict with the procedures set forth in this part 17;

(b) Provide notice of the public hearing required pursuant to subsection (3)(a) of this section to state insurance regulators and appropriate state guaranty associations in states in which the dividing insurer is authorized to do business;

(c) Confirm to the commissioner's satisfaction that the dividing insurer has made reasonable efforts to provide to all policyholders, contract holders, reinsurers, and other persons with an interest in the proposed plan of division at least thirty days' prior notice of the public hearing if the commissioner determines that it would be unreasonable or unfair to not provide such notice to such other persons. For the purposes of this subsection (3)(c), a notice must:

(I) Provide information regarding the proposed division under consideration and the location, date, and time of the public hearing; and

(II) If the dividing insurer has the last-known address or last-known email address of the policyholder, contract holder, reinsurer, or other person on file, either be mailed to the last-known address of such person or sent via electronic means to the last-known email address of such person.

(d) Consider any simultaneous merger or acquisition of a resulting insurer as part of the plan of division;

(e) In the case of a simultaneous merger, apply to the resulting insurer involved in the simultaneous merger the requirements of this part 17 that are applicable to the resulting insurer as merged into the surviving entity in the merger and not to the resulting insurer prior to the merger; and

(f) Consider, among other things, all assets, liabilities, and cash flows, the nature and composition of the assets proposed to be transferred in support of the plan of division, and all proposed assets of the resulting insurers, which consideration must include:

(I) An assessment of the risks and quality, including the liquidity and marketability, of the proposed portfolio of each resulting insurer;

(II) Consideration of asset and liability matching; and

(III) The treatment of the material elements of the portfolio based on statutory accounting practices.

(4) After making the considerations described in subsections (3)(d), (3)(e), and (3)(f) of this section, the commissioner shall approve a plan of division if the commissioner finds that the following requirements are met:

(a) The financial condition of a dividing insurer, a resulting insurer, or an acquiring party of a resulting insurer, if any, will not jeopardize the financial stability of the dividing insurer or prejudice the interests of its policyholders, contract holders, or reinsurers, in each case, in a manner that is unfair to its policyholders, contract holders, or reinsurers;

(b) The terms of the plan of division are fair and reasonable to the dividing insurer's and any resulting insurer's policyholders, contract holders, and reinsurers, if any;

(c) Neither a dividing insurer, a resulting insurer, nor an acquiring party of a resulting insurer, if any, has plans or proposals to:

(I) Liquidate the dividing insurer or any resulting insurer;

(II) Sell assets of the dividing insurer or of any resulting insurer;

(III) Consolidate or merge the dividing insurer or any resulting insurer with a person; or

(IV) Make any other material change in the dividing insurer's or any resulting insurer's business or corporate structure or management that is unfair or unreasonable to the dividing insurer's or resulting insurers' policyholders, contract holders, or reinsurers and not in the public interest;

(d) The competence, experience, and integrity of the persons who would control the operation of a dividing insurer, if it survives the division, and any resulting insurer are such that permitting the division would be consistent with the interest of the dividing insurer's and any resulting insurers' policyholders, contract holders, and reinsurers, if any, and the general public;

(e) The division is not likely to be hazardous or prejudicial to the insurance-buying public;

(f) The interest of the policyholders of the dividing insurer that may become policyholders of a resulting insurer will be adequately protected by the resulting insurer or acquiring party of a resulting insurer, if any;

(g) The dividing insurer, if it survives the division, and any resulting insurers will be solvent upon the consummation of the division;

(h) The assets allocated to the dividing insurer, if it survives the division, and to resulting insurers will not, upon the consummation of the division, be unreasonably small in relation to the business and transactions in which the insurers were engaged or are about to engage;

(i) The proposed division is not being made for the purpose of hindering, delaying, or defrauding any policyholders, contract holders, or reinsurers;

(j) Each resulting insurer that will be a member insurer under the "Life and Health Insurance Protection Association Act", article 20 of this title 10, will be licensed in each line of business in each state where the dividing insurer was licensed with respect to the insurance policies or annuity contracts issued by the dividing insurer that are allocated to that resulting insurer as part of the plan of division; except that the resulting insurer need not be licensed with respect to any line of business in any state where, at the time of division:

(I) The dividing insurer is not licensed with respect to that line of business; or

(II) The state does not provide guaranty association coverage or similar coverage with respect to the allocated policies or contracts; and

(k) If the plan of division allocates policies of long-term care insurance, as defined in section 10-19-103 (5), the liabilities associated with those allocated policies do not constitute more than a de minimus amount of the insurance liabilities allocated to the dividing insurer, if it survives the division, or to any resulting insurer.

(5) A dividing insurer that files a plan of division shall pay all expenses incurred by the commissioner in connection with proceedings under this section, including expenses for attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed plan of division. A dividing insurer may allocate the expenses in the plan of division in the same manner as any other liability.

(6) The commissioner shall select and retain an independent expert who shall review the plan of division and issue a report to the commissioner, which report addresses the following:

(a) The business purposes of the proposed division;

(b) Capital adequacy and risk-based capital, including consideration of the effects of asset quality, nonadmitted assets, and actuarial stresses to reserve assumptions;

(c) Cash flow and reserve adequacy testing, including consideration of the effects of diversification on policy liabilities;

(d) Business plans;

(e) The impact, if any, of concentration of lines of business following the proposed division; and

(f) Management's competence, experience, and integrity.

(7) If the commissioner approves a plan of division, the commissioner shall issue:

(a) An order that is accompanied by findings of fact and conclusions of law; and

(b) A certificate of authority authorizing the resulting insurers to transact the business of insurance in this state; except that the commissioner may waive this requirement if a resulting insurer will not survive a merger simultaneous with the division in accordance with the plan of division.

(8) The conditions in this section for freeing one or more of the resulting insurers from the liabilities of the dividing insurer and for allocating some or all of the liabilities of the dividing insurer are deemed to have been satisfied if the commissioner approves the plan of division in a final order.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 847, § 1, effective September 7.

10-3-1709. Confidentiality - records. (1) All information, documents, materials, and copies of documents and materials submitted to, obtained by, or disclosed to the commissioner in connection with a plan of division or in contemplation of a plan of division, including any information, documents, materials, or copies provided by or on behalf of a domestic stock insurer in advance of its adoption or submission of a plan of division, are confidential and subject to the same protection and treatment described in section 10-3-808 for information and documents disclosed to or obtained by the commissioner in the course of an examination or investigation made under section 10-3-806, until the time that a notice of the hearing required by section 10-3-1708 is issued.

(2) After the issuance of a notice of the hearing required by section 10-3-1708, all business, financial, actuarial, and other proprietary information for which the domestic stock insurer requests confidential treatment, other than the plan of division and any materials incorporated by reference into or otherwise made a part of the plan of division that must not be eligible for confidential treatment after the issuance of a notice of the hearing, continues to be confidential, is not available for public inspection, and is subject to the same protection and treatment as described in section 10-3-808 for information and documents disclosed to or obtained by the commissioner in the course of an examination or investigation made under section 10-3-806. However, if the commissioner determines that the public's interest in making the information available for public inspection outweighs the interest of the dividing insurer in keeping the information confidential, the commissioner may, after notice and an opportunity to be heard, make the information available for public inspection in accordance with the "Colorado Open Records Act", part 2 of article 72 of title 24.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 850, § 1, effective September 7.

10-3-1710. Certificate of division. (1) If the commissioner approves a dividing insurer's plan of division pursuant to section 10-3-1708, an officer or duly authorized representative of the dividing insurer shall sign a certificate of division that sets forth all of the following:

(a) The name of the dividing insurer;

(b) A statement disclosing whether the dividing insurer survived the division. If the dividing insurer survived the division, the certificate of division must include any amendments to the dividing insurer's articles of incorporation or bylaws approved as part of the plan of division.

(c) The name of each resulting insurer that is created by the division;

(d) The date on which the division is effective;

(e) A statement that the division was approved by the commissioner pursuant to section 10-3-1708;

(f) A statement that the dividing insurer provided reasonable notice to each reinsurer that is a party to a reinsurance contract allocated in the plan of division, if any;

(g) The articles of incorporation and bylaws for each resulting insurer created by the division. The articles of incorporation and bylaws of each resulting insurer must comply with the applicable requirements of the laws of this state. The articles of incorporation and bylaws may state the name or address of an incorporator, may be signed, and may include any provision that is not required in a restatement of the articles of incorporation or bylaws.

(h) A reasonable description of the capital, surplus, or other assets and liabilities, including policy liabilities, of the dividing insurer that are to be allocated to each resulting insurer.

(2) A dividing insurer's certificate of division is effective on the date the dividing insurer files the certificate with the commissioner. A division is effective on the date specified in the certificate of division filed in accordance with this section.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 851, § 1, effective September 7.

10-3-1711. After division is effective. (1) (a) On the effective date of a division, if the dividing insurer survives, all of the following apply:

(I) The dividing insurer continues to exist;

(II) The dividing insurer must amend its articles of incorporation if the amendments are provided for in the plan of division; and

(III) The dividing insurer must amend its bylaws if the amendments are provided for in the plan of division.

(b) On the effective date of a division, if the dividing insurer does not survive, then the dividing insurer ceases to exist, and any resulting insurer created by the plan of division comes into existence.

(c) Each resulting insurer holds any capital, surplus, and other assets allocated to the resulting insurer by the plan of division as a successor to the dividing insurer by operation of law and not by transfer, whether directly or indirectly. The articles of incorporation and bylaws, if any, of each resulting insurer are effective when the resulting insurer comes into existence.

(d) All capital, surplus, and other assets of the dividing insurer:

(I) That are allocated by the plan of division vest in the applicable resulting insurer as provided in the plan of division or remain vested in the dividing insurer as provided in the plan of division;

(II) That are not allocated by the plan of division remain vested in the dividing insurer if the dividing insurer survives the division and are allocated to, and vest pro rata in, the resulting insurers individually if the dividing insurer does not survive the division; and

(III) Otherwise vest as provided in this section without transfer, reversion, or impairment.

(e) A resulting insurer to which a cause of action is allocated may be substituted or added in any pending action or proceeding to which the dividing insurer is a party when the division becomes effective.

(f) All liabilities, including policy liabilities, of a dividing insurer are allocated between or among any resulting insurers as provided in section 10-3-1710, and each resulting insurer to which liabilities are allocated is liable only for those liabilities, including policy liabilities, allocated as a successor to the dividing insurer by operation of law, and not by transfer or assumption, whether directly or indirectly.

(g) Any shares in the dividing insurer that are to be converted or canceled in the division are converted or canceled, and the shareholders of those shares are entitled only to the rights provided to the shareholders under the plan of division and any appraisal rights that the shareholders may have pursuant to section 10-3-1713.

(2) Except as provided in the dividing insurer's articles of incorporation or bylaws, a division does not give rise to any rights that a shareholder, director of a domestic stock insurer, or third party would have upon a dissolution, liquidation, or winding up of the dividing insurer.

(3) The allocation to a resulting insurer of capital, surplus, or other asset that is collateral covered by an effective financing statement is not effective until a new effective financing statement naming the resulting insurer as a debtor is effective under the "Uniform Commercial Code", title 4.

(4) Unless otherwise provided in the plan of division, the shares in, and any securities of, each resulting insurer are distributed to the dividing insurer, if it survives the division, or are distributed pro rata to the shareholders of the dividing insurer that do not assert any appraisal rights pursuant to section 10-3-1713.

(5) A division that becomes effective pursuant to this part 17 is not an assignment of any insurance policy, annuity, reinsurance agreement, or other type of contract.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 852, § 1, effective September 7.

10-3-1712. Resulting insurers' liability for allocated assets and debts. (1) Except as expressly provided in this section, when a division becomes effective, by operation of law all of the following apply:

(a) A resulting insurer is individually liable for the liabilities, including policy liabilities:

(I) That the resulting insurer issues, undertakes, or incurs in its own name after the division; and

(II) Of the dividing insurer that are allocated to or remain the liability of the resulting insurer to the extent specified in the plan of division;

(b) The dividing insurer remains responsible for the liabilities, including policy liabilities, of the dividing insurer that are not allocated by the plan of division if the dividing insurer survives the division; and

(c) A resulting insurer is liable pro rata individually for the liabilities, including policy liabilities, of the dividing insurer that are not allocated by the plan of division if the dividing insurer does not survive the division.

(2) Except as otherwise expressly provided in this section, when a division becomes effective, a resulting insurer is not responsible for and does not have liability for:

(a) Any liabilities, including policy liabilities, that another resulting insurer issues, undertakes, or incurs in the resulting insurer's own name after the division; or

(b) Any liabilities, including policy liabilities, of the dividing insurer that are allocated to or remain the liability of another resulting insurer under the plan of division.

(3) If a provision of any evidence of indebtedness, whether secured or unsecured, or a provision of any contract other than an insurance policy, annuity, or reinsurance agreement that was issued, incurred, or executed by the dividing insurer before September 7, 2021, requires the consent of the obligee to a merger of the dividing insurer, or treats such a merger as a default, the provision applies to a division of the dividing insurer as if the division were a merger.

(4) If a division breaches a contractual obligation of the dividing insurer, all resulting insurers are jointly and severally liable for the breach. The validity and effectiveness of the division is not affected by the breach.

(5) A direct or indirect allocation of capital, surplus, assets, or liabilities, including policy liabilities, occurs automatically, by operation of law, and may not be treated as a distribution or transfer for any purpose with respect to either the dividing insurer or any resulting insurer.

(6) Liens, security interests, and other charges on the capital, surplus, or other assets of the dividing insurer are not impaired by the division, notwithstanding any otherwise enforceable allocation of liabilities, including policy liabilities, of the dividing insurer.

(7) If the dividing insurer is bound by a security agreement governed by article 5 or 9 of title 4, or by the substantial equivalent as enacted in any other jurisdiction, and the security agreement provides that the security interest attaches to after-acquired collateral, a resulting insurer is bound by the security agreement.

(8) Unless otherwise provided in the plan of division and specifically approved by the commissioner, an allocation of a policy or other liability may not:

(a) Affect the rights that a policyholder or creditor has under any other law with respect to the policy or other liability; except that the rights are available only against a resulting insurer responsible for the policy or liability under this section; or

(b) Release or reduce the obligation of a reinsurer, surety, or guarantor of the policy or liability.

(9) A resulting insurer is liable only for the liabilities allocated to the resulting insurer in accordance with the plan of division and this section and is not liable for any other liabilities under the common law doctrine of successor liability or any other theory of liability applicable to transferees or assignees of assets.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 853, § 1, effective September 7.

10-3-1713. Shareholder appraisal rights. If a dividing insurer does not survive a division, a shareholder of the dividing insurer is entitled to appraisal rights and to obtain payment of the fair value of the shareholder's shares in the same manner and to the extent provided for a corporation as a party to a merger pursuant to section 7-113-102.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 855, § 1, effective September 7.

10-3-1714. Rules. The commissioner may adopt rules to administer this part 17.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 855, § 1, effective September 7.

10-3-1715. Enforcement by commissioner. The commissioner may take any action within the commissioner's authority to enforce compliance with this part 17.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 855, § 1, effective September 7.

10-3-1716. Merger or consolidation effective with division. (1) To facilitate the merger or consolidation of any resulting insurer with and into another company simultaneously with the effectiveness of a division authorized by this part 17, a dividing insurer, including its officers, directors, and shareholders, may:

(a) Adopt and execute a plan of merger or consolidation on behalf of a resulting insurer;

(b) Execute and deliver documents, plans, certificates, and resolutions; and

(c) Make any filings, in each case, on behalf of the resulting insurer.

(2) If so provided in a plan of merger or consolidation described in this section, the merger or consolidation is effective simultaneously with the effectiveness of a division authorized by this part 17.

(3) On request of the dividing insurer, the commissioner may waive the other requirements of this section with respect to any merger or consolidation involving only domestic stock insurers and may issue the commissioner's final approval of the merger or consolidation as part of the commissioner's approval of a plan of division under this part 17.

Source: L. 2021: Entire part added, (HB 21-1013), ch. 144, p. 855, § 1, effective September 7.

CERTIFIED CAPITAL COMPANIES

ARTICLE 3.5

Certified Capital Companies

Editor's note: (1) This article 3.5 was added in 2001. For amendments to this article 3.5 prior to its repeal in 2025, consult the 2024 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

(2) HB 25-1326 amended § 10-3.5-108 (3)(d), effective August 6, 2025, but those amendments did not take effect due to the repeal of this article 3.5, effective July 1, 2025.

(3) Section 10-3.5-111 provided for the repeal of this article 3.5, effective July 1, 2025. (See L. 2017, p. 1548.)

10-3.5-101 to 10-3.5-111. (Repealed)

PROPERTY AND CASUALTY INSURANCE

ARTICLE 4

Property and Casualty Insurance

Law reviews: For article, "Property Insurance", see 16 Colo. Law. 1828 (1987).

PART 1

GENERAL

10-4-101. Legislative declaration. The general assembly declares that the health, welfare, and safety of the people of the state of Colorado would be enhanced by the expeditious handling of liability claims. The general assembly further declares that the handling of such claims would be expedited if voluntary payment by one person, or on his behalf to an injured person, could not be construed as an admission of fault or liability as to any claim arising out of the same occurrence.

Source: L. 67: p. 972, § 1. **C.R.S. 1963:** § 72-1-58.

10-4-101.5. Definitions. As used in this article 4, unless the context otherwise requires:

(1) "Homeowner's insurance" means insurance that covers damage or loss to all types of homes, including, but not limited to, site-built homes, manufactured homes, factory-built homes, and mobile homes.

Source: L. 2025: Entire section added with relocations, (SB 25-275), ch. 377, p. 2037, § 40, effective August 6.

Editor's note: This section is similar to former § 10-4-110.6 as it existed prior to 2025.

10-4-102. Federal "voluntary fair access to insurance required, property insurance program" - state qualification. In order that this state may share in the provisions of 12 U.S.C. sec. 1749bbb, which makes available to states that qualify with its provisions a federal program of reinsurance against abnormally high property insurance losses resulting from riots and other

civic commotions, the commissioner is authorized to adopt necessary regulations to qualify this state with the provisions of said federal law, but any regulations so authorized by this section shall otherwise comply with the laws of this state and be subject thereto, and such plan shall be in all respects voluntary.

Source: L. 69: p. 512, § 1. **C.R.S. 1963:** § 72-1-61.

10-4-103. Voluntary partial payment of liability claims without admission of liability. No voluntary partial payment of a claim against any person based on alleged liability of that person for injury or property damage arising out of any occurrence shall be construed as an admission of fault or liability, or as a waiver or release of claim, by the person receiving such payment. Such payment, moreover, shall not be admissible in any action, as evidence, for the purpose of determining the amount of any judgment with respect to the same parties as to such occurrence. Upon settlement of the claim, the parties may make any agreement they so desire in respect to all such voluntary partial payments. After entry of judgment, any such payment shall be treated as a credit against the judgment and is deductible from the amount of the judgment. If, after partial voluntary payments are made as provided for in this section, it is determined by final judgment of a court of competent jurisdiction that the payer is liable for an amount less than the voluntary payments already made, the payer shall have no right of action for the recovery of amounts by which the voluntary payments exceed the final judgment. No voluntary partial payments shall be construed to reduce the amount of damages which may be pleaded and proved in a court proceeding between the parties.

Source: L. 67: p. 972, § 2. **C.R.S. 1963:** § 72-1-59.

10-4-104. Competency of minor to contract for insurance - nonavoidance. Any minor sixteen years of age or older may, notwithstanding his or her minority, contract for insurance, including motor vehicle insurance, upon his or her own property or liabilities. The minor is hereby determined to be competent to exercise all rights and powers with respect to or under any such contract as might be exercised by a person of full legal age and may at any time surrender the minor's interest in the contract and give valid discharge for any benefits accruing or money payable thereunder. Having entered into a contract for insurance, the minor is not entitled to rescind, avoid, or repudiate the contract nor to rescind, avoid, or repudiate any exercise of a right or privilege under the contract by reason of minority.

Source: L. 63: p. 573, § 1. **C.R.S. 1963:** § 72-1-54. **L. 2019:** Entire section amended, (HB 19-1023), ch. 239, p. 2361, § 1, effective August 2.

Cross references: For competency of persons to enter into any legal contractual obligation, see § 13-22-101.

10-4-105. Valuation of bonds and policies other than life. For the purpose of establishing the liability of companies doing a surety business and of insurance companies other than life, the amount required to safely reinsure all outstanding risks shall be estimated by taking fifty percent of the gross annual premiums on all surety bonds, risks, and policies in force that

have less than one year to run, and pro rata of all gross premiums on risks that have more than one year to run.

Source: L. 13: p. 350, § 42. **C.L.** § 2515. **CSA:** C. 87, § 56. **CRS 53:** § 72-3-2. **C.R.S. 1963:** § 72-3-2.

10-4-106. Assigned risks. (1) The commissioner may, after consultation with the insurers licensed to write mortgage guaranty insurance in this state, establish or approve a reasonable plan, and rules governing the same, for the equitable apportionment among such insurers of applicants for such insurance who are in good faith entitled to but are unable to procure insurance through ordinary methods, and, when such plan has been approved, all such insurers may subscribe thereto and participate therein. Any applicant for such insurance, any person insured under such plan, and any insurer affected may appeal to the commissioner from any ruling or decision of the manager or committee designated to operate such plan.

(2) Insurance provided under this section shall be provided only for the purposes listed in article 49 of title 7, C.R.S., and may be made in cooperation with the corporation established in said article.

Source: L. 75: Entire section added, p. 270, § 2, effective June 29.

10-4-106.5. Medical malpractice insurers - requirement to provide information to the department of public health and environment. Upon request by the department of public health and environment pursuant to section 25-52-104 (5)(e), an insurer offering a policy of medical malpractice insurance shall provide the department with information regarding the insurer's policies related to labor and delivery services.

Source: L. 2021: Entire section added, (SB 21-193), ch. 433, p. 2859, § 1, effective September 7.

10-4-107. Cancellation of medical malpractice policies. (1) A notice of cancellation of a medical malpractice policy shall be valid only if it is based on one or more of the following reasons:

(a) Nonpayment of premiums; or

(b) The license of the insured health-care provider has been suspended or revoked by the appropriate state regulatory authority; or

(c) The insured knowingly made a false statement on the application for insurance; or

(d) There has been a substantial change in the exposure or risk other than that indicated in the application and underwritten as of the effective date of the policy unless the insured has notified the insurer of the change and the insurer accepts such change.

(2) This section shall not apply to any policy or coverage which has been in effect less than sixty days at the time the notice of cancellation is mailed or delivered by the insurer, unless it is a renewal policy.

(3) This section shall not apply to nonrenewal of a policy.

(4) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 76: Entire section added, p. 365, § 1, effective May 21. **L. 86:** (1)(c) amended and (1)(d) added, p. 572, § 1, effective July 1. **L. 99:** (4) added, p. 389, § 12, effective January 15, 2000.

10-4-108. Notice. (1) No notice of the cancellation of a policy to which section 10-4-107 applies shall be valid unless mailed or delivered by the insurer to the named insured at least ninety days prior to the effective date of cancellation; but, where cancellation is for nonpayment of premium, at least ten days' notice of cancellation accompanied by the reasons therefor shall be given. Unless the reasons of the company are included in the notice of cancellation, the notice of cancellation shall state or be accompanied by a statement that, upon written request of the named insured mailed or delivered to the insurer not less than fifteen days prior to the effective date of cancellation, the insurer will specify the reasons for such cancellation.

(2) When the reason for cancellation does not accompany or is not included in the notice of cancellation, the insurer shall, upon written request of the named insured mailed or delivered to the insurer not less than fifteen days prior to the effective date of cancellation, specify in writing the reason for such cancellation. Such reason shall be mailed or delivered to the named insured within five days after receipt of such request.

(3) This section shall not apply to nonrenewal of a policy.

(4) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 76: Entire section added, p. 365, § 1, effective May 21. **L. 86:** (1) amended, p. 572, § 2, effective July 1. **L. 99:** (4) added, p. 389, § 13, effective January 15, 2000.

10-4-109. Nonrenewal of medical malpractice policies. (1) No insurer shall refuse to renew a policy of medical malpractice insurance unless such insurer or its agent mails or delivers to the named insured, at the last address shown in the insurer's records, at least ninety days' advance notice of its intention not to renew. This section shall not apply:

(a) If the insurer has already manifested its willingness to renew;

(b) Repealed.

(c) If the insured fails to pay any premium deposit required by the insurer for renewal.

(2) Notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other malpractice liability insurance policy with respect to the particular insured, if such policy has substantially the same limits and provisions of coverage.

(3) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

(4) In the event an insurer refuses to renew, the insured may, by written request, demand a written notification of the reasons for nonrenewal. Such notification shall be given the insured within twenty days after receipt of such request.

(5) Any statement of reasons contained in the notice pursuant to subsection (4) of this section shall be privileged and shall not constitute grounds for any action against the insurer or its representatives or any person who in good faith furnished to the insurer the information upon which the statement is based.

(6) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 76: Entire section added, p. 365, § 1, effective May 21. **L. 86:** IP(1) amended and (1)(b) repealed, pp. 573, 575, §§ 3, 7, effective July 1. **L. 99:** (6) added, p. 389, § 14, effective January 15, 2000.

10-4-109.5. Notice of intent prior to unilateral increase in premium or decrease in coverage previously provided in medical malpractice policies. (1) No insurer shall increase the premium unilaterally or decrease the coverage benefits previously provided as contained in a medical malpractice policy unless such insurer mails by first-class mail to the named insured, at the last address shown in the insurer's records, at least ninety days' advance notice, accompanied by the reason therefor, of the company's intention to increase the premium unilaterally or decrease the coverage benefits provided on renewal.

(2) A notice of a decrease in coverage benefits previously provided pursuant to this section shall be valid only if it sets forth the reason for the decrease and is based on one or more of the following reasons:

(a) Nonpayment of premium;

(b) A false statement knowingly made by the insured on the application for insurance;

(c) A substantial change in the exposure or risk other than that indicated in the application and underwritten as of the effective date of the policy unless the insured has notified the insurer of the change and the insurer accepts such change.

(3) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 86: Entire section added, p. 573, § 4, effective July 1. **L. 99:** (3) added, p. 389, § 15, effective January 15, 2000.

10-4-109.6. Medical malpractice insurers - protections relating to reproductive health care - definition. (1) An insurer that issues medical malpractice insurance shall not take a prohibited action against an applicant for or the named insured under a medical malpractice policy in this state solely because the applicant or insured has provided, or assisted in the provision of, a legally protected health-care activity, as defined in section 12-30-121 (1)(d), in this state, so long as the care provided by the applicant or insured was consistent with generally accepted standards of practice under Colorado law and did not otherwise violate Colorado law.

(2) As used in this section, "prohibited action" means:

(a) Refusing to issue a medical malpractice policy;

(b) Canceling or terminating a medical malpractice policy;

(c) Refusing to renew a medical malpractice policy; or

(d) Imposing any sanctions, fines, penalties, or rate increases.

Source: L. 2023: Entire section added, (SB 23-188), ch. 68, p. 242, § 2, effective April 14.

Cross references: For the legislative declaration in SB 23-188, see section 1 of chapter 68, Session Laws of Colorado 2023.

10-4-109.7. Notice of intent prior to cancellation of certain policies of insurance. (1) No insurer shall cancel a policy of insurance that provides coverages on commercial exposures such as general comprehensive liability, municipal liability, automobile liability and physical damage, fidelity and surety, fire and allied lines, inland marine, errors and omissions, excess liability, products liability, police liability, professional liability, or false arrest insurance unless such insurer mails by first-class mail to the named insured, at the last address shown in the insurer's records, at least forty-five days in advance a notice of the company's intention to cancel; but, where cancellation is for nonpayment of premium, at least ten days' notice of cancellation accompanied by the reasons therefor shall be given.

(2) A notice of cancellation pursuant to this section shall be valid only if it is based on one or more of the following reasons:

(a) Nonpayment of premium;

(b) A false statement knowingly made by the insured on the application for insurance;

(c) A substantial change in the exposure or risk other than that indicated in the application and underwritten as of the effective date of the policy unless the insured has notified the insurer of the change and the insurer accepts such change.

(3) This section shall not apply to insurance companies authorized to write surplus line insurance in Colorado.

(4) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 86: Entire section added, p. 573, § 4, effective July 1. **L. 87:** (1) amended and (3) added, p. 425, § 2, effective May 1. **L. 99:** (4) added, p. 389, § 16, effective January 15, 2000.

10-4-110. Notice of intent prior to nonrenewal of certain policies of insurance. (1) No insurer shall refuse to renew a policy of insurance that provides coverages on commercial exposures such as general comprehensive liability, municipal liability, automobile liability and physical damage, fidelity and surety, fire and allied lines, inland marine, errors and omissions, excess liability, products liability, police liability, professional liability, or false arrest insurance unless such insurer mails by first-class mail to the named insured, at the last address shown in the insurer's records, at least forty-five days in advance a notice of the company's intention not to renew.

(2) Repealed.

(3) The provisions of this section shall not apply:

(a) Repealed.

(b) If the insured fails to pay any premium deposit required by the insurer for renewal;

(c) To any policy or coverage which has been in effect less than sixty days, unless it is a renewal policy.

(4) An insurer's failure to mail notice of intent shall be considered a manifestation of its willingness to renew.

(5) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

(6) This section shall not apply to insurance companies authorized to write surplus line insurance in Colorado.

(7) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 77: Entire section added, p. 511, § 1, effective July 1. **L. 86:** (1) amended and (2) and (3)(a) repealed, pp. 574, 575, §§ 5, 7, effective July 1. **L. 87:** (1) amended and (6) added, p. 426, § 3, effective May 1. **L. 99:** (7) added, p. 390, § 17, effective January 15, 2000.

10-4-110.3. Exclusions where claim involves sexual misconduct - void. (1) No insurer, in a policy of professional malpractice insurance, shall attempt to nullify or limit its stated liability with regard to claims not relating to sexual misconduct in cases where:

(a) There is an allegation or proof of a claim of sexual misconduct by the insured; and

(b) The policy requires aggregation of all damages under the liability limit for sexual misconduct.

(2) Any policy provision that violates subsection (1) of this section is hereby declared contrary to public policy and is void and unenforceable.

(3) This section shall not apply to nonadmitted insurers approved pursuant to article 5 of this title.

Source: L. 95: Entire section added, p. 865, § 1, effective May 24.

10-4-110.4. Exclusion - claims involving loss in progress not known to insured. (1) A provision in a liability insurance policy issued to a construction professional excluding or limiting coverage for one or more claims arising from bodily injury, property damage, advertising injury, or personal injury that occurs before the policy's inception date and that continues, worsens, or progresses when the policy is in effect is void and unenforceable if the exclusion or limitation applies to an injury or damage that was unknown to the insured at the policy's inception date.

(2) Any provision in an insurance policy issued in violation of this section is void and unenforceable as against public policy. A court shall construe an insurance policy containing a provision that is unenforceable under this section as if the provision was not a part of the policy when the policy was issued.

(3) This section applies only to an insurance policy that covers occurrences of damage or injury during the policy period and that insures a construction professional for liability arising from construction-related work.

Source: L. 2010: Entire section added, (HB 10-1394), ch. 253, p. 1128, § 2, effective May 21.

10-4-110.5. Notice of intent prior to unilateral increase in premium or decrease in coverage previously provided in certain policies of insurance. (1) No insurer shall increase the premium unilaterally or decrease the coverage benefits on renewal of a policy of insurance that provides coverages on commercial exposures such as general comprehensive liability, municipal liability, automobile liability and physical damage, fidelity and surety, fire and allied lines, inland marine, errors and omissions, excess liability, products liability, police liability, professional liability, or false arrest insurance unless the insurer mails by first-class mail to the named insured, at the last address shown in the insurer's records, at least forty-five days in advance a notice, accompanied by the reasons therefor, stating the renewal terms and the amount of premium due. If the insurer fails to furnish the renewal terms and the statement of the amount of premium due at least forty-five days prior to the expiration date of the policy, the insurer shall automatically extend the existing policy for a period of forty-five days and the premium for this extended period shall be prorated based on the premium applicable to the existing policy. If the insurer fails to meet the requirements of this section prior to the expiration date of the existing policy, the insurer shall be deemed to have renewed the insured's policy for an identical policy period at the same terms, conditions, and premium as the existing policy.

(2) A notice of a decrease in coverage benefits during the term of a policy of insurance identified in subsection (1) of this section shall be valid only if it sets forth the reason for the decrease and is based on one or more of the following reasons:

(a) Nonpayment of premium;

(b) A false statement knowingly made by the insured on the application for insurance;

(c) A substantial change in the exposure or risk other than that indicated in the application and underwritten as of the effective date of the policy unless the insured has notified the insurer of the change and the insurer accepts such change.

(3) This section shall not apply to insurance companies authorized to write surplus line insurance in Colorado.

Source: L. 86: Entire section added, p. 574, § 6, effective July 1. **L. 87:** (1) amended and (3) added, p. 426, § 4, effective May 1.

10-4-110.6. Homeowner's insurance - definition. (Repealed)

Source: L. 2004: Entire section added, p. 1972, § 2, effective August 4; entire section added, p. 1981, § 2, effective January 1, 2005. **L. 2025:** Entire section repealed, (SB 25-275), ch. 377, p. 2109, § 336, effective August 6.

Editor's note: This section was relocated to § 10-4-101.5 in 2025.

10-4-110.7. Cancellation or nonrenewal - homeowner's insurance policies. (1) (a) If an insurer issues a binder of insurance during a period in which the insurer assesses the risk related to an individual's real and personal property for the purposes of homeowner's insurance,

the insurer shall provide notice to the potential insured that the documents are only a binder and subject to cancellation.

(b) The commissioner may promulgate a rule or issue a bulletin concerning disclosure requirements for a binder of insurance for homeowner's insurance.

(2) (a) If an insurer uses underwriting criteria based on an individual's credit score, the claims history of the property, or the claims history of the applicant, the insurer shall notify the applicant of the use of such criteria during the application process.

(b) If an insurer uses claims experience for the property and such claims history results in an adverse action to the applicant or policyholder, the insurer shall disclose to the applicant or policyholder the specific claim information that resulted in the adverse action.

(3) An insurer shall not cancel or refuse to renew a policy of homeowner's insurance unless such insurer mails, by first-class mail to the named insured, at the last address shown in the insurer's records, at least sixty days in advance, a notice of its intended action that specifically states the reasons for proposing to take such action; except that, where cancellation is for nonpayment of premium, the insurer shall provide at least ten days' notice of cancellation accompanied by the reasons for taking such action.

(4) An insurer offering homeowner's insurance in this state shall file with the commissioner the underwriting methodologies used by the insurer. Such underwriting methodologies are not public records and are exempted from article 72 of title 24, C.R.S., and are proprietary and not subject to public examination; except that the commissioner may use information from the underwriting methodologies filed pursuant to this subsection (4) that does not identify a specific insurer for consumer information publications concerning homeowner's insurance.

(5) If an insurer issues a binder or a policy of insurance during a period in which the insurer assesses the risk related to an individual's real and personal property for the purposes of homeowner's insurance, the insurer shall provide notice to the potential insured that the documents are conditional and that the insurer has thirty business days, commencing on the effective date of the conditional coverage, to evaluate the issuance of a policy for homeowner's insurance. If the insurer refuses to issue a policy of homeowner's insurance or cancels a conditional policy that has been issued as of an effective date within this thirty-business-day period, the insurer shall notify the homeowner of the insurer's decision. If, prior to the expiration of the thirty-business-day period, the insurer obtains information showing an articulable and reasonable basis on which the insurer might be justified in canceling coverage and the insurer believes that further investigation or repair of the property is necessary, the thirty-business-day period may be extended. The insurer shall complete any inspection associated with the underwriting of the new property within the thirty-business-day period.

Source: L. 87: Entire section added, p. 427, § 5, effective May 1. **L. 2004:** Entire section amended, p. 1971, § 1, effective August 4; entire section amended, p. 1980, § 1, effective January 1, 2005. **L. 2023:** (3) amended, (HB 23-1174), ch. 168, p. 820, § 2, effective August 7.

Editor's note: Amendments to this section by House Bill 04-1292 and House Bill 04-1236 were harmonized.

10-4-110.8. Homeowner's insurance - prohibited and required practices - estimates of replacement value - additional living expense coverage - copies of policies - personal property contents coverage - inventory of personal property - requirements concerning total loss scenarios resulting from wildfire disasters - definitions - rules. (1) An insurer may not cancel or fail to renew coverage of an insured solely because the insured inquires about coverage for homeowner's insurance and the inquiry is not related to an actual claim to the property insured.

(2) An insurer may only provide information regarding claims to an entity that compiles or monitors personal claim or loss experience shared by insurers for underwriting or rating purposes.

(3) As used in this section, unless the context otherwise requires:

(a) "Additional living expense coverage" or "ALE" covers increased living expenses during the time required to repair or replace damage to the policyholder's dwelling unit following an insured loss or, if the policyholder permanently relocates, the time required to move the policyholder's household to a new location.

(b) "Claim" includes a demand for payment of a benefit by the insured, the payment of a covered benefit by an insurer, a loss reserve established by the insurer, a loss adjustment expense incurred by the insurer, or a payment made to the insured.

(c) "Dwelling" means a single-family home, other than a mobile home, condominium, or manufactured home, that is used as a primary residence by the owner of the dwelling.

(d) "Extended replacement cost coverage" pays a designated amount above the policy limit to replace a damaged structure if necessary under current building conditions.

(d.7) "Inflation protection coverage" means coverage that provides automatic adjustments of the coverage amount on the dwelling or structure being insured to protect against the impact of inflation.

(e) "Inquiry" means a request for information regarding the terms, conditions, or coverages afforded under an insurance contract.

(f) "Law and ordinance coverage" means coverage for increased costs of demolition, construction, renovation, or repair associated with the enforcement of building ordinances and laws.

(g) (I) "Owner-occupied residence" means a residence that is occupied primarily for the use of the owner and the owner's designees.

(II) "Owner-occupied residence" includes, but is not limited to, an owner-occupied primary residence.

(III) "Owner-occupied residence" does not include any property that is insured under a commercial insurance or agribusiness policy.

(h) "Recoverable depreciation" means the difference between the cost to replace insured property and the actual cash value of the property.

(i) "Wildfire" means a rapidly spreading fire that is difficult to bring under control in an area that includes combustible vegetation, such as trees, grass, brush, or bushes, which fire causes widespread or severe damage to property, regardless of the original source of ignition of the fire.

(4) Every insurer issuing a policy of homeowner's insurance shall comply with section 10-3-1104 (1)(h) and all other provisions of part 11 of article 3 of this title.

(5) (a) In a common interest community, as defined in section 38-33.3-103 (8), C.R.S., a unit owner may file a claim against the policy of the unit owners' association to the same extent, and with the same effect, as if the unit owner were a named insured if the following conditions are met:

(I) The unit owner has contacted the executive board or the association's managing agent in writing, and in accordance with any applicable association policies or procedures for owner-initiated insurance claims, regarding the subject matter of the claim;

(II) The unit owner has given the association at least fifteen days to respond in writing, and, if so requested, has given the association's agent a reasonable opportunity to inspect the damage; and

(III) The subject matter of the claim falls within the association's insurance responsibilities.

(b) The association's insurer, when determining premiums to be charged to the association, shall not take into account any request by a unit owner for a clarification of coverage.

(6) (a) (I) Before issuance or renewal of a replacement-cost homeowner's insurance policy whose dwelling limit is equal to or greater than the estimated replacement cost of the residence, the insurer shall make available to an applicant the opportunity to obtain extended replacement-cost coverage and law and ordinance coverage. At a minimum, the insurer shall offer law and ordinance coverage in an amount of insurance equal to twenty percent of the limit of the insurance for the dwelling and extended replacement-cost coverage in an amount of insurance that is at least fifty percent of the limit of the insurance for the dwelling. Information provided must be accompanied by an explanation of the purpose, terms, and cost of these coverages. This subsection (6)(a) does not apply to any homeowner's insurance policy that already includes guaranteed replacement cost coverage, inflation protection coverage, extended replacement-cost coverage, or law and ordinance coverage in amounts greater than or equal to the amounts specified in this subsection (6)(a).

(II) No later than January 1, 2025, and as prescribed by the commissioner by rule, the insurer shall:

(A) List on the declaration page of the policy, in bold and in twelve-point type, whether a consumer purchased or rejected the additional coverages listed in this subsection (6)(a); and

(B) Provide the premium cost associated with the rejected additional coverages listed in this subsection (6)(a) in a separate notice with the application or renewal of the policy.

(b) All homeowner's insurance replacement-cost policies for a dwelling must include additional living expense coverage. This coverage must be available for a period of at least twelve months and is subject to other policy provisions. Insurers shall offer policyholders the opportunity to purchase a total of twenty-four months of ALE coverage and give an applicant an explanation of the purpose, terms, and cost of this coverage. This paragraph (b) does not apply to any homeowner's insurance policy that already includes at least twenty-four months of ALE coverage as a standard provision.

(7) (a) The text of all endorsements, summary disclosure forms, and homeowner's insurance policies must not exceed the tenth-grade reading level, as measured by the Flesch-Kincaid grade level formula, or must not score less than fifty as measured by the Flesch reading ease formula. Insurers shall revise all homeowner's insurance policies issued or renewed in

Colorado on or after January 1, 2015, to comply with this subsection (7). Thereafter, all homeowner's insurance policies must comply with this subsection (7).

(b) For the purposes of this subsection (7):

(I) A contraction, hyphenated word, or numbers and letters, when separated by spaces, count as one word;

(II) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, count as a sentence; and

(III) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, a pronunciation containing fewer syllables may be used.

(IV) "Text" includes all printed matter except the following:

(A) The name and address of the insurer; the name, number, or title of the policy; the table of contents or index; captions and subcaptions; and specification pages, schedules, or tables; and

(B) Any policy language that is drafted to conform to the requirements of a federal law or regulation; any policy language required by a collectively bargained agreement; any medical terminology; any words that are defined in the policy; and any policy language required by law or regulation if the insurer identifies the language or terminology excepted and certifies in writing that the language or terminology is entitled to be excepted.

(8) The insurer must consider the following factors as a basis for establishing the reconstruction cost of a dwelling:

(a) The reconstruction cost estimated from the annual report prepared pursuant to section 10-1-144;

(b) The reconstruction cost estimating software used and the software estimate;

(c) Specific reconstruction expenses, including:

(I) Labor, building materials, and supplies;

(II) A contractor's overhead and profit;

(III) Demolition and debris removal;

(IV) Cost of permits and architect's plans and fees; and

(V) Features of the structure, including:

(A) The foundation type;

(B) The type of frame;

(C) Roofing materials and type of roof;

(D) Siding materials and type of siding;

(E) Square footage;

(F) Number of stories;

(G) Any wall heights that are not standard;

(H) Interior features and finishes, such as the heating and air conditioning system, walls, flooring, ceiling, fireplaces, kitchen, and bathrooms;

(I) The age of the original structure or the year of the original structure's construction; and

(J) The size and type of any attached garage; and

(d) An estimate from a contractor or an architect licensed pursuant to article 120 of title 12, if submitted by the policyholder.

(9) At renewal of a homeowner's insurance policy, the insurer shall provide written notification to the policyholder describing changes in insurance policy language that are applicable to that renewal period.

(9.5) (a) At application and renewal of a replacement-cost homeowner's insurance policy for a dwelling that is issued or renewed on and after January 1, 2025, the insurer shall:

(I) Provide the applicant or policyholder with an estimate of the cost necessary to reconstruct the covered structure;

(II) Disclose to the applicant or policyholder, in a form and manner prescribed by the commissioner by rule:

(A) How the estimate was calculated, taking into account the factors listed in subsection (8) of this section; and

(B) The reconstruction costs for homes as detailed in the annual report required in section 10-1-144 for the same geographic area of the insured's home;

(III) Provide copies of any generated estimates from any software or tools or services used by the insurer to establish the reconstruction costs; and

(IV) Provide the applicant or policyholder with the web address of, or a link to, the report prepared pursuant to section 10-1-144.

(b) An insurer otherwise subject to this subsection (9.5) does not have to comply with the requirements of this subsection (9.5) if:

(I) Within the two years prior to the offer of renewal of the homeowner's insurance policy, the policyholder has requested and the insurer has provided coverage limits greater than the limits previously selected by the policyholder; or

(II) In connection with its annual offer to renew the policy, the insurer has offered the policyholder, on an every-other-year basis, the right to recalculate the reconstruction cost estimate, and the policy includes inflation protection coverage.

(10) (a) A homeowner's insurance carrier shall make available to a policyholder an electronic or paper copy of the policyholder's insurance policy, including the declaration page and any endorsements, within three business days after a request from the policyholder. The policyholder shall determine the method of delivery.

(b) A homeowner's insurance carrier shall make available to a policyholder a certified copy of the policyholder's insurance policy within thirty calendar days after a written request from the policyholder is received by the insurance carrier's registered agent.

(c) (I) A homeowner's insurance carrier that fails to make available a certified copy of an insurance policy to a requesting policyholder within thirty calendar days pursuant to subsection (10)(b) of this section is liable to the requesting policyholder for a penalty in the amount of fifty dollars per day, beginning on the thirty-first calendar day after the insurance carrier's registered agent receives the policyholder's request. The penalty accrues daily until the insurance carrier makes the certified copy of the homeowner's insurance policy available to the requesting policyholder.

(II) A homeowner's insurance carrier that violates subsection (10)(b) of this section is responsible for reasonable attorney fees and costs that a requesting policyholder incurs enforcing this subsection (10)(c).

(11) (a) In the event of a total loss of the contents of an owner-occupied primary residence that was furnished at the time of loss, the insurer shall offer the policyholder a minimum of thirty percent, or a larger percent by mutual agreement of the policyholder and

insurer, of the value of the contents coverage reflected in the declaration page of the homeowner's policy without requiring submittal of a written inventory of the contents. In order to receive up to the full value of the contents coverage, the policyholder may accept the offer under this paragraph (a) and submit a written inventory as required by the insurer.

(b) If the policyholder receives the depreciated value of contents insured under a policy, the insurer must make available to the insured the methodology used for determining the depreciated value of the insured contents.

(c) (I) An insurer shall allow the policyholder at least three hundred sixty-five days after a total loss claim to submit an inventory of lost or damaged property.

(II) An insurer shall allow the policyholder at least three hundred sixty-five days after expiration of ALE to replace property and receive recoverable depreciation on that property.

(12) (a) Notwithstanding any provision of a homeowner's insurance policy that requires the policyholder to file suit against the insurer, in the case of any dispute, within a period of time that is shorter than required by the applicable statute of limitations provided by law, a homeowner may file such a suit within the period of time allowed by the applicable statute of limitations; except that this paragraph (a):

(I) Does not revive a cause of action that, as of May 10, 2013, has already been barred by contract; and

(II) Applies only to a cause of action that, as of May 10, 2013, has not been barred by contract.

(b) On and after January 1, 2014, an insurer shall not issue or renew a homeowner's insurance policy that requires the policyholder to file suit against the insurer, in the case of any dispute, within a period of time that is shorter than required by the applicable statute of limitations provided by law.

(13) In offering, issuing, or renewing a homeowner's insurance policy in this state, an insurer shall comply with the following minimum requirements concerning coverage provided under the policy to policyholders to protect them from damages that occur in the event of a total loss of an owner-occupied residence, including the contents of the owner-occupied residence, which loss occurs as a result of a wildfire disaster that the governor declares pursuant to section 24-33.5-704:

(a) A policy of homeowner's insurance may not limit or deny a payment of the building code upgrade cost or a payment of any extended replacement cost available under the policy coverage for a policyholder's structure that was a total loss on the basis that the policyholder decided to rebuild in a new location or to purchase an existing structure in a new location if the policy otherwise covers the replacement cost or building code upgrade cost; except that the measure of indemnity may not exceed the replacement cost, including the upgrade costs and extended replacement cost for repairing, rebuilding, or replacing the structure at the original location of the loss.

(b) If a policy of homeowner's insurance requires a policyholder to repair, rebuild, or replace damaged or lost property in order to collect the full replacement cost for the property, the insurer, subject to the policy limits, shall:

(I) Allow the policyholder at least thirty-six months to submit receipts and invoices for the replacement costs of the insured owner-occupied residence, which period begins on the date upon which the insurer provides the initial payment toward the actual cash value of the damage or loss; and

(II) Provide that, in addition to the period described in subsection (13)(b)(I) of this section, the policyholder has the option to twice extend such period by six months if the policyholder, acting in good faith and with reasonable diligence, encounters unavoidable delays in obtaining a construction permit, lacks necessary construction materials, lacks available contractors to perform necessary work, or encounters other circumstances beyond the policyholder's control. This subsection (13)(b)(II) does not prohibit an insurer from allowing a policyholder additional time to collect the full replacement cost for lost or damaged property or for additional living expenses.

(c) The policy must include additional living expense coverage to apply in the event of such a loss. Notwithstanding subsection (6)(b) of this section, additional living expense coverage must be available for a period of at least twenty-four months, and the insurer shall offer the policyholder the opportunity to twice extend such period by six months if the policyholder, acting in good faith and with reasonable diligence, encounters a delay or delays in receiving necessary permit approvals for, or reconstruction of, the insured owner-occupied residence, which delays are beyond the control of the policyholder.

(d) The policy must provide that, notwithstanding subsection (11)(c) of this section, to replace personal property and receive recoverable depreciation on that property, an insurer shall allow the policyholder the greater of:

(I) At least three hundred sixty-five days after the expiration of ALE; or

(II) Thirty-six months after the insurer provides the policyholder the first payment toward the actual cash value of such loss.

(e) The policy must provide that the insurer will pay the policyholder for the loss of use of the insured property within twenty days after the insurer receives documentation of such loss, which documentation may include a signed lease that obligates the policyholder to pay for temporary replacement housing; except that:

(I) If a policyholder provides a signed lease as documentation, the insurer may pay the policyholder in monthly or other increments, in accordance with the terms of the lease; and

(II) Alternatively, an insurer may provide advance rent payments for housing for the policyholder, family members, livestock, and pets, as necessary.

(f) The policy must provide that the policyholder may either:

(I) Replace the insured owner-occupied residence at the current location or another location, in either of which case the calculation of the replacement cost of the insured owner-occupied residence shall not include consideration of the value of the land upon which the replacement residence is located; or

(II) Use the proceeds from the policy to purchase an existing residence at a new location, in which case the calculation of the replacement cost of the insured owner-occupied residence shall not include consideration of the value of the land upon which the existing residence is located.

(g) The policy must allow a policyholder to use claims payments resulting from coverage against the loss of outbuildings, dwelling extensions, and other structures to pay the costs of a replacement residence if the coverage limit that applies to the policyholder's owner-occupied residence is insufficient to pay for rebuilding or replacing the owner-occupied residence. Any claims payments for losses pursuant to this subsection (13)(g) for which replacement cost coverage is applicable shall be for the full replacement value of the loss without requiring actual replacement of the other structures. Claims payments for other

structures in excess of the amount applied toward the necessary cost to rebuild or replace the damaged or destroyed dwelling shall be paid according to the terms of the policy.

(h) Within a reasonable amount of time after receiving a claim under an issued policy, an insurer shall provide to the policyholder:

(I) Appropriate contact information that allows for direct contact with either an employee of the insurer or a representative who is capable of elevating complaints or inquiries to an employee of the insurer;

(II) At least one means of communication during regular business hours; and

(III) A written status report if, within a six-month period, the policyholder is assigned a third or subsequent adjuster to be primarily responsible for a claim. The written status report must include a summary of any decisions or actions that are substantially related to the disposition of a claim, including the amount of losses to structures or contents, the retention or consultation of design or construction professionals, the amount of coverage for losses to structures or contents, and all items of dispute.

(14) If a homeowner's insurance policyholder experiences a total loss of the contents of an owner-occupied residence that was documented as being furnished at the time of loss as a result of a wildfire disaster that is declared by the governor pursuant to section 24-33.5-704, the insurer shall:

(a) Notwithstanding subsection (11)(a) of this section, offer the policyholder a minimum of sixty-five percent, or a larger percent by mutual agreement of the policyholder and insurer, of the limit of the contents coverage indicated in the declaration page of the policy without requiring the policyholder to submit a written inventory of the contents;

(b) Notify the policyholder that:

(I) Acceptance of the money described in subsection (14)(a) of this section does not change the benefits available under the policy;

(II) Additional money may be available if the policyholder submits an inventory; and

(III) The insurer is required, pursuant to subsection (11)(b) of this section, to disclose its methodology for determining the depreciated value of the contents of insured property;

(c) (I) If the policyholder submits an inventory of personal property losses in an amount that exceeds the amount paid to the policyholder pursuant to subsection (14)(a) of this section:

(A) Request any additional information concerning the inventory no later than thirty days after receiving the inventory; and

(B) Provide payment for any covered and undisputed items within thirty days after receiving the inventory.

(II) The commissioner shall adopt rules to simplify the process for policyholders to submit an inventory for personal property losses and expedite reimbursement for such losses.

(d) Provide payment for covered costs associated with the removal of debris within sixty days after receiving an invoice, receipt, or other documentation indicating the date and cost of the removal of the debris; except that, in cases where debris removal is conducted by, or in coordination with, governmental entities, payment for covered costs for removal of debris will be provided within a reasonable amount of time; and

(e) Provide payment for any covered loss of trees, shrubs, and landscaping within thirty days after the insurer receives documentation of such loss, such as documentation from a reputable landscaping company, showing the number and nature of trees, shrubs, and landscaping features damaged or destroyed.

(15) The commissioner may adopt rules as necessary to implement this section, including rules regarding:

(a) The information that insurers must consider in estimating reconstruction costs;

(b) The use of reconstructing cost estimator tools and services; and

(c) The requirements to provide information in the summary disclosure form to consumers that explains replacement cost coverage, actual cash value coverage, and the ability of consumers to purchase affordable coverage.

(16) (a) An insurer shall not refuse to issue, cancel, refuse to renew, or increase a premium or rate for a homeowner's insurance policy, a dwelling fire insurance policy, a commercial policy for multifamily units, or a policy to cover the contents of a structure used for a residence and occupied by an owner or renter based on the breed or mixture of breeds of a dog that is kept at the dwelling, multifamily unit, or structure used as a residence.

(b) This subsection (16) does not prohibit an insurer from refusing to issue, canceling, refusing to renew, or imposing a reasonable increase to a premium or rate for a homeowner's insurance policy, a dwelling fire insurance policy, a commercial policy for multifamily units, or a policy to cover the contents of a structure used for a residence and occupied by an owner or renter based on sound underwriting and actuarial principles on the basis that a particular dog kept at the dwelling, multifamily unit, or structure used as a residence is known to be dangerous or has been declared to be dangerous in accordance with section 18-9-204.5.

(c) An insurer may not ask or otherwise inquire about the specific breed or mixture of breeds of a dog that is kept at the dwelling except to ask if the dog is known to be dangerous or has been declared to be dangerous in accordance with section 18-9-204.5.

(d) As used in this subsection (16), "dwelling" includes a dwelling unit as defined in section 38-12-502 (3).

Source: L. 2004: Entire section added, p. 1972, § 3, effective August 4; entire section added, p. 1981, § 2, effective January 1, 2005. **L. 2005:** (3) and (4) amended and (5) added, p. 1390, § 20, effective January 1, 2006. **L. 2006:** (5) amended, p. 1226, § 16, effective May 26. **L. 2013:** (12) added, (HB 13-1225), ch. 183, p. 672, § 2, effective May 10; (3) amended and (6) to (11) added, (HB 13-1225), ch. 183, p. 672, § 2, effective January 1, 2014. **L. 2022:** IP(3) and (3)(g) amended and (3)(h), (3)(i), (13), (14), and (15) added, (HB 22-1111), ch. 305, p. 2204, § 1, effective August 10. **L. 2023:** (3)(d.7) and (9.5) added and (6)(a) and (15) amended, (HB 23-1174), ch. 168, p. 820, § 3, effective August 7; (16) added, (HB 23-1068), ch. 416, p. 2463, § 2, effective January 1, 2024; (8) amended, (HB 23-1174), ch. 168, p. 820, § 3, effective January 1, 2025. **L. 2025:** (10) amended, (HB 25-1322), ch. 406, p. 2315, § 1, effective August 6; (16)(a) and (16)(b) amended, (HB 25-1207), ch. 224, p. 1025, § 1, effective August 6.

Editor's note: (1) Section 2(2) of chapter 406 (HB 25-1322), Session Laws of Colorado 2025, provides that the act changing this section applies to requests made on or after August 6, 2025.

(2) Section 3(2) of chapter 224 (HB 25-1207), Session Laws of Colorado 2025, provides that section 1 of the act changing this section applies to insurance policies issued or renewed on or after August 6, 2025.

Cross references: (1) In 2013, subsection (3) was amended and subsections (6) to (12) were added by the "Homeowner's Insurance Reform Act of 2013". For the short title, see section 1 of chapter 183, Session Laws of Colorado 2013.

(2) For the legislative declaration in HB 23-1068, see section 1 of chapter 416, Session Laws of Colorado 2023.

10-4-110.9. Fire insurance - issuance and renewal of policies within federally designated disaster areas. (1) No insurer shall refuse to issue a fire insurance policy for any property located within a federally designated disaster area, so designated because of wildfire, where such refusal is based on such property's zip code, county location, or distance from any wildfire. This section shall not apply to property that is located within an immediately threatened area as designated by the appropriate state, local, or federal official.

(2) An insurer shall not refuse to renew an existing fire insurance policy for property that is within an area that has been declared a federally designated disaster area for any reason that is related to wildfire. As a condition of such renewal, an insurer may require a property owner to take reasonable actions to reduce the risk of fire to such property.

(3) If a property owner refinances a mortgage on an insured property that falls within an area that has been declared a federally designated disaster area because of wildfire, the insurer of such property shall continue to provide coverage for the remaining term of the existing fire insurance policy, adjusted as required by the mortgage lender for any increase or decrease in the value of such property. Such required adjustment shall not conflict with the requirements of section 10-4-114.

(4) The commissioner of insurance may adopt rules as necessary for implementation of this section.

Source: L. 2002, 3rd Ex. Sess.: Entire section added, p. 50, § 1, effective July 18.

10-4-111. Summary disclosure forms required. (1) Every insurer issuing policies of dwelling fire insurance, homeowner's insurance, or automobile insurance subject to the provisions of part 6 of this article shall, as a condition of doing business in this state, have on file for public inspection at the division a summary disclosure form that contains a simple explanation of the major coverages and exclusions of such policies of insurance together with a recitation of general factors considered in cancellation, nonrenewal, and increase in premium situations. Each summary disclosure form shall provide notice in bold face letters that the policyholder should read the policy for complete details, and such disclosure form shall not be construed to replace any provision of the policy itself. In the event of any conflict between the policy and the disclosure form, the provisions of the policy shall prevail.

(2) Every insurer shall update disclosure forms periodically subject to changes in major coverages and exclusions of such policies of insurance and changes in factors considered in cancellation, nonrenewal, and increase in premium situations.

(3) Every insurer or its designated agent shall furnish the required disclosure form to:

(a) Applicants for insurance coverage at the time of the initial insurance purchase;

(b) Policyholders of any renewal policy when there are changes in major coverages and exclusions or changes in factors considered in cancellation, nonrenewal, and increase in premium situations; and

(c) Homeowner's insurance policyholders at least annually.

(4) Any insurer who violates the provisions of subsection (1) of this section shall be deemed to have engaged in unfair or deceptive acts or practices prohibited by section 10-3-1104 (1)(a)(I) and shall be subject to the penalties provided in section 10-3-1108 and 10-3-1109.

(5) In addition to the disclosure requirements in this section, every insurer or producer who issues automobile insurance policies pursuant to part 6 of this article shall comply with the disclosure requirements in section 10-4-636.

Source: L. 79: Entire section added, p. 360, § 6, effective July 1. **L. 92:** Entire section amended, p. 1557, § 55, effective May 20. **L. 2006:** (1) amended, p. 1490, § 11, effective June 1; (1) amended and (5) added, p. 37, § 1, effective January 1, 2007. **L. 2013:** (3) amended, (HB 13-1225), ch. 183, p. 675, § 3, effective January 1, 2014.

Editor's note: Amendments to subsection (1) by House Bill 06-1391 and House Bill 06-1030 were harmonized.

Cross references: In 2013, subsection (3) was amended by the "Homeowner's Insurance Reform Act of 2013". For the short title, see section 1 of chapter 183, Session Laws of Colorado 2013.

10-4-112. Property damage - time of payment. (Repealed)

Source: L. 86: Entire section added, p. 576, § 1, effective April 3. **L. 2024:** Entire section repealed, (HB 24-1011), ch. 189, p. 1074, § 4, effective May 17.

10-4-113. Exemptions. (1) The commissioner shall have authority to grant reasonable exemptions from the provisions of sections 10-4-107, 10-4-108 (1), 10-4-109 (1), 10-4-109.5, 10-4-109.7, 10-4-110 (1), and 10-4-110.5 if compliance therewith is shown to be impracticable. Such exemptions may be granted to individual companies or by insurance line, type, or class and may be based on any of the following reasons:

(a) If the primary insurer, due to forces outside its control, has lost all or a significant portion of its reinsurance and the insurer can provide proof that the continuance of coverage or the continuance of the same premium and coverage would endanger the direct insurer's solvency;

(b) If a policy issued in this state covers risks with multistate locations, except with respect to coverages applicable to locations within this state;

(c) If the insurer is obligated and fails to send advance notice of cancellation or nonrenewal to any designated mortgagee or loss payee or motor carrier commission;

(d) If the insured has replaced his coverage or has specifically requested cancellation. The insurer must maintain in its file properly documented proof that termination was made at the request of the insured. This applies also to reduction in coverage specifically requested by the insured.

(e) If the policy has been in effect for less than sixty days at the time the notice is mailed or delivered, unless the policy is a renewal policy, and there has been a material misrepresentation or nondisclosure to the insurer of a material fact at the time of acceptance of the risk;

(f) If the policy is a policy written for a period of less than six months or a binder with a specific expiration date and the insured knows in advance that coverage will not be continued on expiration;

(g) If an insurer has become insolvent and cancellation is ordered by a rehabilitator or liquidator;

(h) If a risk is canceled and rewritten with the same insurer in order to obtain common expiration dates;

(i) If a named insured fails to comply with loss control recommendations which the insured agreed would be implemented as a condition of issuance of the policy;

(j) Such other exemptions as the commissioner may determine are reasonable and necessary; or

(k) If the insurer is providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 86: Entire section added, p. 578, § 1, effective July 1. **L. 99:** (1)(k) added, p. 390, § 18, effective January 15, 2000.

10-4-114. Requirements on hazard insurance coverage for loans secured by real property. (1) No lender shall require a borrower under a loan secured by real property to provide hazard insurance coverage on that property in an amount exceeding the replacement value of the improvements on the property.

(2) Any person harmed by a violation of this section shall be entitled to obtain injunctive relief and may recover damages and reasonable attorney fees and costs.

(3) A violation of this section does not affect the validity of the loan or the mortgage or deed of trust.

Source: L. 88: Entire section added, p. 403, § 2, effective April 29.

10-4-115. Private utilization review. (1) As used in this section, unless the context otherwise requires:

(a) "Private utilization review organization" means an entity, other than a hospital or public reviewer following federal guidelines, which conducts utilization review.

(b) "Utilization review" means an evaluation of the necessity, appropriateness, and efficiency of the use of health-care services, procedures, and facilities, but does not include any independent medical examination provided for in any policy of insurance.

(2) An insurance carrier regulated pursuant to the provisions of this article may contract with any private utilization review organization and receive from that private utilization review organization a utilization review opinion. If the insurance carrier relies on the opinion of the private utilization review organization resulting in a decision to not pay benefits that an appropriate fact finder later determines were due and owing, then the insurance carrier shall be responsible to pay the past due benefits in addition to interest and costs. Nothing in this subsection (2) shall be construed to affect or limit the commissioner's power to regulate under the provisions of section 10-3-1104 (1)(h), nor shall anything in this subsection (2) limit or affect the insured's remedies under part 6 of this article, or any common law remedy.

Source: L. 93: Entire section added, p. 493, § 1, effective April 26. **L. 2003:** (2) amended, p. 1571, § 6, effective July 1.

10-4-116. Use of credit information. (1) An insurer that offers personal lines of property and casualty insurance shall not:

(a) Use an insurance score that is calculated using income, gender, address, United States postal zip code, ethnic group, religion, marital status, or nationality of the consumer;

(b) Deny, cancel, or fail to renew a policy of personal lines of property and casualty insurance on the basis of credit information, without consideration of any other applicable underwriting factor that is independent of credit information prohibited pursuant to paragraph (a) of this subsection (1);

(c) Base an insured's renewal rates for personal lines of property and casualty insurance upon credit information, without consideration of any other applicable factor independent of credit information;

(d) Take an adverse action against a consumer because he or she does not have a credit card account, without consideration of any other applicable factor independent of credit information;

(e) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal lines of property and casualty insurance issued in this state, unless the insurer does one of the following:

(I) Treats the consumer in a manner otherwise approved by the commissioner, if the insurer presents information that such an absence or inability relates to the risk for the insurer;

(II) Treats the consumer as if he or she had neutral credit information, as defined by the insurer; or

(III) Excludes the use of credit information as a factor and uses only other underwriting criteria;

(f) Take an adverse action against a consumer based on credit information, unless the insurer obtains and uses a credit report issued or an insurance score calculated within ninety days before the date the policy is first written or renewal is issued;

(g) Use credit information unless, not later than every thirty-six months following the last time that the insurer obtained current information for the consumer, the insurer recalculates the consumer's insurance score or obtains an updated credit report. Notwithstanding any provision of this section to the contrary, an insurer:

(I) At annual renewal, upon the request of a consumer or the consumer's agent, shall reunderwrite and rerate the policy based upon a current credit report or insurance score. An insurer may recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once during a twelve-month period.

(II) May obtain current credit information upon a renewal before the thirty-sixth month of coverage, if obtaining current credit information is consistent with the insurer's underwriting guidelines;

(III) Notwithstanding subparagraph (I) of this paragraph (g), need not obtain current credit information for an insured if one of the following situations apply:

(A) The insurer is treating the insured in a manner otherwise approved by the commissioner;

(B) The insured is in the most-favorably-priced tier of the insurer, within a group of affiliated insurers; except that the insurer may order a credit report if ordering the credit report is consistent with its underwriting guidelines;

(C) Credit was not used for underwriting or rating the insured when the insured's initial policy of insurance was written; except that an insurer may use credit for underwriting or rating the insured upon renewal if the use of credit is consistent with its underwriting guidelines; or

(D) The insurer reevaluates the insured beginning no later than thirty-six months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

(h) Use the following as a negative factor in an insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal lines of property and casualty insurance:

(I) Credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information;

(II) Inquiries relating to insurance coverage, if so identified on a consumer's credit report;

(III) Collection accounts with a medical industry code, if so identified on the consumer's credit report;

(IV) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the motor vehicle lending industry and made within thirty days after one another, unless only one inquiry is considered;

(V) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within thirty days of one another, unless only one inquiry is considered;

(VI) Identity theft that may be sufficiently and independently corroborated;

(VII) Credit information adversely impacted by a dissolution of marriage or by the credit information of a former spouse.

(2) If it is determined through the dispute resolution process as set forth in the federal "Fair Credit Reporting Act", 15 U.S.C. sec. 1681i (a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of a determination from either the consumer reporting agency or from the insured, the insurer shall reunderwrite and rerate the consumer within thirty days after receiving the notice. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid a premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last twelve months of coverage or the actual policy period.

(3) (a) If an insurer offering personal lines of property and casualty coverage uses credit information in underwriting or rating a consumer, the insurer or the producer shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. The disclosure shall be either in writing or in the same medium as the application for insurance is taken. The insurer may provide the disclosure statement required pursuant to this subsection (3) to an insured on a renewal policy, if the consumer has previously been provided a copy of the disclosure statement.

(b) Use of the following disclosure statement shall constitute compliance with the provisions of this subsection (3); except that an insurer may use different terms or phrases to communicate the same meaning:

In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score.

(4) If an insurer takes an adverse action based upon credit information, the insurer shall meet the notice requirements of this subsection (4). Specifically, an insurer shall:

(a) Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal "Fair Credit Reporting Act", 15 U.S.C. sec. 1681m (a); and

(b) Provide notification to the consumer explaining the reason for the adverse action. The reasons shall be provided in sufficiently clear and specific language so that a person may identify the basis for the insurer's decision to take adverse action. The notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history", "poor credit rating", or "poor insurance score" does not meet the explanation requirements of this subsection (4). Standardized credit explanations provided by consumer reporting agencies or other third-party vendors are deemed to comply with this subsection (4).

(5) An insurer that uses insurance scores to underwrite and rate risk shall file its scoring models or other scoring processes with the commissioner. A third party may file scoring models on behalf of an insurer. A filing that includes insurance scoring may include loss experience justifying the use of credit information. The insurer may request that information requested pursuant to this subsection (5) not be open to public inspection or considered an open record pursuant to article 72 of title 24, C.R.S.

(6) An insurer shall indemnify, defend, and hold a producer harmless against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of the producer who obtains or uses credit information or insurance scores for an insurer, so long as the producer follows the instructions of or procedures established by the insurer and complies with any applicable law or rule. Nothing in this section shall be construed to provide a consumer or insured with a cause of action that does not exist in the absence of this section.

(7) (a) A consumer reporting agency shall not provide or sell data or lists that include information that, in whole or in part, was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Information that may not be provided or sold includes, but is not limited to, the expiration dates of an insurance policy or other information that may identify periods in which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

(b) The restrictions provided in paragraph (a) of this subsection (7) shall not apply to data or lists the consumer reporting agency supplies to the insurance producer from whom information was received, the insurer on behalf of whom the producer acted, or such insurer's affiliates or holding companies.

(c) Nothing in this subsection (7) shall be construed to restrict an insurer from being able to obtain a claims history report or a motor vehicle report.

(8) For the purposes of this section, unless the context otherwise requires:

(a) "Adverse action" means a denial or cancellation of, an increase in any charge for, or a reduction or other unfavorable change in the terms of coverage or amount of any insurance existing or applied for in connection with the underwriting of personal lines of property and casualty insurance coverages.

(b) "Affiliate" means a company that controls, is controlled by, or is under common control with another insurer.

(c) "Applicant" means a person who has applied to be covered under a policy of personal lines of property and casualty insurance.

(d) "Beneficiary or claimant" includes an insured person and a third-party claimant.

(e) "Consumer" means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of personal lines of property and casualty insurance or an application for personal lines of property and casualty insurance coverage.

(f) "Consumer reporting agency" shall have the same meaning as in section 5-16-103 (6).

(g) "Credit information" means credit-related information derived from a credit report itself or provided on an application for personal lines of property and casualty insurance. Information that is not credit-related shall not be considered "credit information" regardless of whether it is contained in a credit report or in an application or is used to calculate an insurance score.

(h) "Credit report" means a written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's creditworthiness, credit standing, or credit capacity that is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal lines of property and casualty insurance premiums, eligibility for coverage, or tier placement.

(i) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purpose of predicting the future insurance loss exposure of an individual applicant or insured.

Source: L. 2004: Entire section added, p. 1974, § 1, effective January 1, 2005. **L. 2017:** (8)(f) amended, (HB 17-1238), ch. 260, p. 1172, § 15, effective August 9.

10-4-117. Loss history information report - notice to insured - definition. (1) Each insurer shall print in at least twelve-point bold-faced type, on the first page of each packet containing the insurance policy and each packet containing the renewal notice for homeowner's insurance or as a separate document:

(a) Information regarding how an insured may obtain a free copy of his or her loss history information report;

(b) A toll-free telephone number that the insured may call to obtain the loss history information report; and

(c) A website address that the insured may access to obtain the loss history information report.

(2) For the purposes of this section, "loss history information report" means a compilation of an insured's prior loss history information used by an insurer in the insured's homeowner's insurance underwriting process. Such information may include, but need not be limited to, the insured's name, date of birth, and claim information such as date of loss, type of loss, and the amounts paid for the loss, if any, or any other information that may negatively affect the insured's rate of homeowner's insurance or the ability to obtain homeowner's insurance. A loss history information report shall include only information regarding claims made to an insurer and shall not include information regarding inquiries made to the insurer.

Source: L. 2004: Entire section added, p. 1972, § 2, effective August 4; entire section added, p. 1981, § 2, effective January 1, 2005.

Editor's note: This section was originally numbered as § 10-4-116 in House Bill 04-1236 but was renumbered on revision and harmonized with § 10-4-117 as enacted by House Bill 04-1292.

10-4-118. Severability. If any provision or clause of this part 1 or application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this part 1 that can be given effect without the invalid provision or application, and to this end the provisions of this title are declared to be severable.

Source: L. 2004: Entire section added, p. 1973, § 4, effective August 4; entire section added, p. 1981, § 2, effective January 1, 2005.

Editor's note: This section was originally numbered as § 10-4-117 in House Bill 04-1236 but was renumbered on revision and is identical to § 10-4-118 as enacted by House Bill 04-1292.

10-4-119. Monthly and electronic payment of premiums. An insurer offering personal lines of property and casualty insurance shall offer each policyholder the option to pay his or her insurance premiums monthly and to make premium payments by automatic electronic transfer. The insurer shall not be required to offer such payment options if an applicant or policyholder has previously made one or more premium payments that were dishonored because the account closed, the account had insufficient funds, or for any other similar reason for nonpayment.

Source: L. 2005: Entire section added, p. 345, § 1, effective December 31.

10-4-120. Unfair or discriminatory trade practices - legislative declaration. (1) (a) The general assembly determines that competition is fundamental to the free market system and that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest-quality commodities and services, and the best environment for democratic and social institutions. Therefore, the right of the individual to choose a repair business is a matter of statewide concern.

(b) The general assembly declares that the purposes of this section are to:

(I) Safeguard the public against monopolies, trusts, and market barriers;

(II) Foster and encourage competition by prohibiting unfair and discriminatory insurance practices that impede fair and honest competition;

(III) Ensure that all consumers benefit from competition and the expansion of choices in the marketplace; and

(IV) Enhance Colorado's economic development.

(c) This section shall be liberally construed so that its beneficial purposes may be served.

(2) An insurer or its agent that issues or renews a policy that insures real or personal property shall not:

(a) Directly or indirectly require that appraisals or repairs to the property be made or not be made by a specified repair business;

(b) Represent to a beneficiary or claimant who is making a claim under a policy that the use of, or the failure to use, a particular repair business may result in the nonpayment or delayed payment of a claim;

(c) Intimidate, coerce, threaten, or induce by incentive a beneficiary or claimant to use a particular repair business for repairs; except that an inducement by incentive does not include warranty or guaranty repairs;

(d) Contract with a person to manage, handle, or arrange insurance repair work or to act as an agent for the insurer if:

(I) The contract requires a particular repair business to do claims work for the insurer at a price established by the insurer; and

(II) The person retains a percentage of any compensation paid by the insurer;

(e) Use disincentives to discourage a beneficiary or claimant from using a particular repair business; except that a disincentive does not include warranty or guaranty repairs;

(f) Solicit or accept a referral fee or compensation in exchange for referring the beneficiary or claimant to a repair facility;

(g) Require the beneficiary or claimant to travel an unreasonable distance to choose a repair facility;

(h) Misinform a beneficiary or claimant to induce the use of a particular repair business; or

(i) In the settlement of a liability claim by a third party against a beneficiary or claimant for property damage claimed by the third party, require a third-party claimant to have repairs done by a particular repair business.

(3) An insurer or its agent that issues or renews a policy that insures real or personal property shall:

(a) Supply the beneficiary or claimant with a copy of the estimate upon which the settlement is based, when partial losses are settled on the basis of an estimate prepared by or for the insurer;

(b) Require that any estimate prepared by or for the insurer covering damages that are visible or evident at the time of inspection is adequate to restore the property within a reasonable time to its condition before the loss, in accordance with applicable policy provisions;

(c) Pay for repair services and products based on a prevailing competitive price, as established by competitive bids, generally accepted insurer-based methodology, or market surveys that determine a fair and reasonable market price for similar services;

(d) Orally or in writing disclose to a beneficiary or claimant that the beneficiary or claimant may freely choose any repair business;

(e) Assume all reasonable costs sufficient to pay for the beneficiary's or claimant's repairs including materials or parts, less any applicable deductible or reduction for comparative negligence;

(f) Promptly pay the cost of property repair services and products from any repair facility location that is within a reasonable distance, less any applicable deductible amount payable by the beneficiary or claimant according to the terms of the insurance policy, at no less than the prevailing competitive market price in the same geographic area; and

(g) Disclose to the beneficiary or claimant any ownership interest in, or ownership by or through an affiliation with, a repair business recommended by the insurer when the recommendation is made.

(4) An insurer is not required to furnish the notices required by this section more than once to each beneficiary or claimant for each claim.

(5) A beneficiary, claimant, or repair business may submit a written, documented complaint to the commissioner alleging a violation of this section.

(6) Notwithstanding any other provision of this section, an insurer or its agent shall inform the beneficiary or claimant that he or she may select any repair business of his or her choosing, and, if the insurer chooses, the insurer may also inform the beneficiary or claimant that the insurer can provide a list of repair businesses for the beneficiary or claimant to consider.

Source: L. 2007: Entire section added, p. 972, § 1, effective May 18.

10-4-121. Authority of insurer to protect policyholders' property - emergency. Notwithstanding any other provision of law, an insurer may provide services protecting the property of its policyholders in the event of an emergency.

Source: L. 2014: Entire section added, (SB 14-097), ch. 62, p. 282, § 2, effective July 1.

10-4-122. Market study - property and casualty insurance - associations of common interest communities and lodging facilities owners - definitions - report - repeal. (1) As used in this section, unless the context otherwise requires:

(a) "Admitted insurance" means any property and casualty insurance written by an insurer that holds a certificate of authority to conduct the business of insurance in Colorado.

(b) "Association" means a unit owners' association of a common interest community, as defined in section 38-33.3-103 (3).

(c) "Captive insurance company" has the meaning set forth in section 10-6-103 (2).

(d) "Common interest community" has the meaning set forth in section 38-33.3-103 (8).

(e) "Condominium unit" has the meaning set forth in section 38-33-103 (1).

(f) "Nonadmitted insurance" has the meaning set forth in section 10-5-101.2 (10).

(g) "Owner of lodging facilities" or "owner" means a person that possesses an ownership interest in:

(I) A hotel, as defined in section 44-3-103 (21); or

(II) A lodging facility.

(2) The commissioner shall conduct a study of the market for admitted insurance policies issued by insurers to associations and to owners of lodging facilities. To the extent practicable, the study must include consideration of:

(a) Current market conditions, including:

(I) The availability of coverage, as differentiated by county or zip code, in the markets for admitted insurance and nonadmitted insurance and through self-insured mechanisms, including captive insurance companies;

(II) The affordability of coverage, as differentiated by property value and by county or zip code; and

(III) Identification of areas of Colorado with particular availability concerns;

(b) Recommendations regarding potential measures and programs to ensure the long-term sustainability and availability of property and casualty insurance policies issued to associations and owners;

(c) Whether any captive insurance companies have been formed by an association or an owner; and

(d) Whether the formation of a captive insurance company by an association or an owner could impact current market conditions.

(3) (a) The commissioner may contract with a third party to conduct the study required in subsection (2) of this section. The commissioner is not required to comply with the "Procurement Code", articles 101 to 112 of title 24, for purposes of this subsection (3); except that the commissioner shall use a competitive process pursuant to the "Procurement Code" to select a third party to conduct the study.

(b) The commissioner and any third party conducting the study shall engage with and seek input from insurers, consumer groups, and other interested parties.

(4) As part of the study, the commissioner may collect data from each insurer in the markets for admitted insurance and nonadmitted insurance, including:

(a) The number and location of each association and owner in Colorado for which the insurer provides coverage through a property and casualty insurance policy;

(b) The criteria used by the insurer to underwrite property and casualty insurance policies issued to associations and owners;

(c) Combined loss and expense ratios incurred by the insurer from issuing property and casualty insurance policies to associations and owners; and

(d) Any other data the commissioner identifies as relevant to evaluating current market conditions and developing proposed availability and affordability solutions.

(5) Information submitted by an insurer pursuant to subsection (4) of this section is subject to public inspection only to the extent allowed under the "Colorado Open Records Act", part 2 of article 72 of title 24. The division and any third-party contractor shall not disclose trade secrets or confidential or proprietary information to any person that is not authorized to access the information.

(6) The commissioner shall prepare a report summarizing the results of the study required by this section. On or before January 1, 2026, the commissioner shall submit the report to the joint budget committee, to the business affairs and labor committee of the house of representatives, and to the business, labor, and technology committee of the senate, or any successor committees. To the extent feasible, the commissioner may collect data concerning self-insured mechanisms, including captive insurance companies, and include such information in the report.

(7) This section is repealed, effective July 1, 2026.

Source: L. 2024: Entire section added, (HB 24-1108), ch. 312, p. 2097, § 1, effective August 7.

10-4-123. Policy summary of major provisions - choice of language - penalty for insurer noncompliance - rules - definitions. (1) (a) (I) On or after January 1, 2026, an insurer that issues insurance policies in this state shall provide a summary document in Spanish and that satisfies the requirements of subsection (1)(a)(II) of this section to:

(A) The named insured under an insurance policy issued in this state, if the named insured completed and returned to the insurer the language selection form in accordance with subsection (2)(c) of this section; or

(B) All named insureds under insurance policies issued in this state in accordance with subsection (2)(d) of this section.

(II) The summary document required by this subsection (1) must:

(A) Provide a general explanation of the coverages and exclusions under the insurance policy, consistent with the requirements of section 10-4-111;

(B) Include the coverages selected by the named insured under the insurance policy;

(C) Include any mandatory coverages rejected by the named insured pursuant to section 10-4-609 or 10-4-635 and any exclusions selected by the named insured pursuant to section 10-4-630; and

(D) Be in the form prescribed by, and in a written or electronic format as determined by, the commissioner by rule.

(III) By December 31, 2024, the commissioner, by rule, shall create and approve a summary document form, including specifying the format, for insurers to use to comply with this subsection (1).

(b) With regard to a summary document that an insurer provides to the named insured:

(I) The summary document is for informational purposes only;

(II) The actual terms of the named insured's insurance policy prevail over the information provided in the summary document;

(III) In the case of a dispute, the insurance policy is controlling, and a court shall rely on the English-language version of the insurance policy to resolve the dispute;

(IV) The information in the summary document does not create rights or obligations on the part of the insurer, the named insured, the producer, or the state; and

(V) The summary document is not intended to be a substitute for the actual insurance policy written in English.

(2) (a) Except as provided in subsection (2)(d) of this section, an insurer that issues insurance policies in this state on or after January 1, 2026, shall:

(I) Offer an applicant for a new or renewal insurance policy a form to select the summary document described in subsection (1) of this section; and

(II) Provide the language selection form in English and Spanish.

(b) For new insurance policies issued on or after January 1, 2026, the insurer shall provide the language selection form described in subsection (2)(a) of this section to the applicant at the time of application for the insurance policy. For renewal insurance policies, the insurer shall offer the language selection form once, at the first renewal of the insurance policy that arises on or after January 1, 2026; except that, if the insurer previously offered the language selection form to the named insured at the time of application for a new insurance policy, the

insurer is not required to offer the language selection form at the time of renewal of that insurance policy.

(c) If the applicant for a new or renewal insurance policy returns the language selection form described in subsection (2)(a) of this section to the insurer, the insurer shall provide the summary document described in subsection (1) of this section upon issuance of the initial insurance policy and at every renewal of the insurance policy. If the applicant does not return the language selection form to the insurer within sixty days after the insurer sends the language selection form, the insurer is not required to provide the summary document described in subsection (1) of this section.

(d) Instead of offering an applicant for a new or renewal insurance policy a language selection form pursuant to subsection (2)(a) of this section, an insurer may comply with this section by providing all named insureds under its insurance policies issued in this state the summary document described in subsection (1) of this section.

(e) By December 31, 2024, the commissioner, by rule, shall create and approve a language selection form, in English and Spanish, for insurers to use to comply with this subsection (2).

(3) (a) On and after January 1, 2026, if an insurer fails to comply with the requirements of this section, any written rejections of mandatory coverages pursuant to section 10-4-609 or 10-4-635 or exclusions pursuant to section 10-4-630 are voidable at the named insured's election. If the named insured elects to void the coverage rejection or exclusion:

(I) The named insured may recover reasonable attorney fees and court costs incurred in reinstating or rewriting the coverage; and

(II) The insurer shall not require the named insured to pay any premium during the policy period applicable for the reinstated or rewritten coverage.

(b) If the named insured does not reject coverage in future policy periods, the insurer may charge a premium for the coverage in future policy periods.

(4) As used in this section:

(a) "Insurance policy" means a personal automobile policy of insurance.

(b) "Producer" has the same meaning as "insurance producer" as set forth in section 10-2-103 (6).

Source: L. 2024: Entire section added, (HB 24-1440), ch. 320, p. 2139, § 1, effective May 31.

10-4-124. Homeowner insurance - underwriting - wildfire risk models - requirements - definitions - rules. [*Editor's note: This section is effective July 1, 2026.*]

(1) As used in this section, unless the context otherwise requires:

(a) "Catastrophe model" means a tool, instrumentality, means, or product, including a map-based tool, a computer-based tool, or a simulation that is used by an insurer to estimate potential losses from catastrophic events.

(b) "Community-level mitigation action" means a science-based mitigation action as demonstrated by a community- or neighborhood-level designation or certification or as undertaken by a government entity.

(c) "Property-specific mitigation action" means a science-based mitigation action as demonstrated by the "Wildfire Prepared Home" designation from the Insurance Institute for

Business and Home Safety or by a similar mitigation program that includes a verification and certification process.

(d) "Wildfire risk model" means a tool, instrumentality, means, or product, including a map-based tool, a computer-based tool, or a simulation, that is used by an insurer in whole or in part, to measure or assess the wildfire risk associated with a residential property or community for purposes of rating, classifying, or pricing based on wildfire risk or estimating risks or losses corresponding to the wildfire risk classifications.

(2) (a) An insurer that uses a wildfire risk model or a catastrophe model or scoring method to assign risk shall provide the wildfire risk model, catastrophe model, or scoring method used to assign risk, including a description of the model, the impact of the model on rates, an actuarial justification for all rating factors, including mitigation discounts offered, and an explanation of the use of the model in underwriting decisions, to the commissioner as part of the insurer's complete filing.

(b) To the extent data is available and as established by rule, an insurer shall submit to the division, as part of their rate filings, information on how and whether the models used for underwriting and rating account for state-wide mitigation activities, such as forest treatment, investments in wildfire fighting and mitigation equipment, and utility wildfire mitigation activities undertaken pursuant to a wildfire mitigation plan approved by the public utilities commission.

(c) Models submitted to the commissioner pursuant to this section shall be treated as trade secrets and not subject to disclosure under the "Colorado Open Records Act", part 2 of article 72 of title 24.

(3) An insurer that uses a wildfire risk model, a catastrophe model, or a combination of models shall ensure the following factors are either incorporated in the wildfire risk model, catastrophe model, or combination of models or are otherwise demonstrably included in the insurer's underwriting and pricing:

(a) Property-specific mitigation actions such as establishing defensible space, incorporating building hardening measures, or receiving certification from an entity with expertise in mitigation of properties against wildfire; and

(b) Community-level mitigation activities or designations, including forest treatment and other fuel reduction activities.

(4) If an insurer does not incorporate property-specific and community-level mitigation actions into its models, the insurer shall provide discounts to policyholders who can demonstrate that property-specific mitigation actions have been undertaken on the property or community-level mitigation actions have been undertaken in sufficient proximity to the property to reduce the risk of loss.

(5) An insurer shall post on its public website readily accessible information on the premium discounts, incentives, or other premium adjustments that are available to policyholders who undertake property-specific mitigation actions or provide evidence of community-level mitigation actions and the process for appealing a wildfire risk score. The website shall identify, as applicable:

(a) Property-specific mitigation actions for the policyholder to undertake and community-level mitigation actions that could result in a discount, incentive, or other premium adjustment; and

(b) The amount of the discount, incentive, or other premium adjustment associated with each action.

(6) (a) An insurer that provides a mitigation discount or that uses a wildfire risk model or risk score to underwrite, nonrenew, price, create a rate differential, or surcharge the premium based upon the policyholder's or applicant's wildfire risk shall provide an annual written notice to each policyholder or applicant upon application for property insurance of the applicable mitigation discounts, the wildfire risk score, and any other wildfire risk classification used by the insurer to underwrite, nonrenew, price, create a rate differential, or surcharge the premium based upon the policyholder's or applicant's wildfire risk.

(b) The notice shall include:

(I) A plain-language explanation of the wildfire risk score or other wildfire risk classification, including an explanation that insurers may use different models and have different risk score ranges that could result in different risk scores from other insurers;

(II) The range of the scores or classifications that could potentially be assigned to the property;

(III) The relative position of the score or classification assigned to the property within that range of possible scores or classifications provided by the insurer's risk model;

(IV) A written explanation of why the policyholder or applicant received the assigned score or classification that identifies the primary features of the property that influenced the assignment of the score or classification; and

(V) The impact, if any, that each property-specific mitigation or community-level mitigation action could have on a wildfire risk score or classification assigned to the property.

(7) The insurer shall provide the wildfire risk score or classification to the policyholder or applicant:

(a) For applicants, no later than fifteen days after the submission of the applicant's completed application to the insurer;

(b) For policyholders, in the offer of renewal;

(c) For policyholders that are not being offered a renewal, with the nonrenewal notice; and

(d) For a policyholder or applicant, if the policyholder or applicant has completed a property-specific mitigation action or provides evidence of a community-level mitigation action in sufficient proximity to the property to reduce the risk of loss since the time of the last application to or renewal by the insurer, no later than thirty days after the submission to the insurer of the policyholder's or applicant's request that the insurer provide a revised wildfire risk score or wildfire risk classification.

(8) A policyholder or applicant for a policy of property insurance whose wildfire risk model score, wildfire risk classification assigned to the property, or applicable mitigation discount is inaccurate and provides evidence of the property-specific or community-level mitigation action may appeal the score directly to the insurer. The insurer shall notify the policyholder or applicant in writing of the right to appeal the wildfire risk score or other wildfire risk classification or applicable mitigation discount when the score or classification or discount is provided to the policyholder or applicant as required by subsection (6) of this section. If the policyholder or applicant appeals the wildfire risk score or other wildfire risk classification or applicable wildfire discount, the insurer shall acknowledge receipt of the appeal in writing within ten calendar days after receipt of the appeal. The insurer shall respond to the appeal in

writing with a reconsideration and decision within thirty calendar days after receiving the appeal. If an appeal is denied, the insurer shall, upon request by the commissioner, forward a copy of the appeal and the insurer's response to the commissioner.

(9) This section applies to property insurance coverage provided by the fair access to insurance requirements plan association created in section 10-4-1804.

(10) This section applies only to homeowner's insurance policies as defined in section 10-4-110.6, property insurance policies covering residential condominium units as defined in section 38-33-103 (1), and multifamily residential housing as defined in section 24-32-3701 (9).

(11) The commissioner may adopt rules to implement this section.

Source: L. 2025: Entire section added, (HB 25-1182), ch. 278, p. 1443, § 1, effective July 1, 2026.

PART 2

FIRE, MARINE, AND INLAND MARINE INSURANCE - RATES AND RATING ORGANIZATIONS

10-4-201 to 10-4-217. (Repealed)

Source: L. 79: Entire part repealed, p. 379, § 19, effective July 1.

Editor's note: This part 2 was numbered primarily as article 11 of chapter 72, C.R.S. 1963. For amendments to this part 2 prior to its repeal in 1979, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

Cross references: For current provisions concerning rate regulation of fire and inland marine insurance, see § 10-4-401 (3)(b).

PART 3

BONDS EXECUTED BY QUALIFIED SURETY COMPANIES

Editor's note: This part 3 was numbered primarily as article 12 of chapter 72, C.R.S. 1963. The substantive provisions of this part 3 were repealed and reenacted in 1979, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this part 3 prior to 1979, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated.

10-4-301. Bond executed by surety company. (1) Whenever any bond, undertaking, recognizance, or other obligation is, by law or the charter, ordinance, rules, or regulations of any municipality, board, body, organization, court, judge, or public officer, required or permitted to

be made, given, tendered, or filed with surety and whenever the performance of any act, duty, contract, or obligation or the refraining from any act is required or permitted to be guaranteed, such bond, undertaking, obligation, recognizance, or guaranty may be executed as surety by a company qualified as provided in this title. Such execution by the company of such bond, undertaking, obligation, recognizance, or guaranty shall be in all respects a full and complete compliance with every requirement of every law, charter, ordinance, rule, or regulation that the bond, undertaking, obligation, recognizance, or guaranty was executed by one or more sureties or that sureties shall be residents or householders or freeholders, or either, or both, or possess any other qualifications.

(2) All courts, judges, heads of departments, boards, bodies, municipalities, and public officers of every character shall accept and treat such bond, undertaking, obligation, recognizance, or guaranty, when so executed by such company, as conforming to and fully and completely complying with every such requirement of every such law, charter, ordinance, rule, or regulation; except that such company may be required to justify, in such terms and for such amounts as may be satisfactory, to the court, person, or body authorized to approve such surety.

Source: L. 79: Entire part R&RE, p. 360, § 7, effective July 1.

Editor's note: This section is similar to former § 10-4-321 as it existed prior to 1979.

10-4-302. Release of surety - other security. Any surety upon the bond of any state, county, municipal, judicial district, irrigation district, or court officer shall be released from further liability as such surety for such officer by filing, with the person having authority to approve said bond or with whom said bond is directed to be filed, a notice that said surety is unwilling to continue to be surety for such officer. When any such notice is filed, written notice thereof shall immediately be given to such officer, who shall thereupon file other security to be approved as provided by law. If such officer, within ten days after the service of such notice upon him, does not file such bond to be approved, the office shall become vacant, and the vacancy shall be filled in the manner provided by law. If a new bond is given by any officer, as provided, the former surety shall be entirely released and discharged from all liability incurred by such officer from and after the time of giving of such notice, and the sureties to the new bond shall be liable therefor as provided in such bond.

Source: L. 79: Entire part R&RE, p. 361, § 7, effective July 1.

Editor's note: This section is similar to former § 10-4-322 as it existed prior to 1979.

10-4-303. Application for release of surety - refund. When any company, surety upon the official bond of any trustee, committee, conservator, guardian, assignee, receiver, executor, administrator, or other fiduciary in this state desires to be released from such obligation, such surety shall file its application for such release in the court having jurisdiction of such fiduciary, and, thereupon, the clerk of such court shall issue, under the seal thereof, a notice to such fiduciary requiring him to furnish a new bond, with sureties to be approved by the court, within ten days after the date of the service of said notice. Such notice may be served in the manner provided by law for the service of a summons in a civil action. If such fiduciary fails to furnish

such bond within the time prescribed, he shall be summarily removed from office, and a new trustee, committee, conservator, guardian, assignee, receiver, executor, administrator, or other fiduciary shall be forthwith appointed. From and after the time when such new bond is furnished and approved, or such new fiduciary appointed and qualified, the surety making such application shall be released from all liability upon its bond, except for such default or other misconduct on the part of such fiduciary as occurred prior thereto. If any surety has been released or withdrawn as provided in this title, and if the principal accounts in due form of law for all of his acts and doings and all trust funds or estate in his hands and secured by such bond, and if such account has been approved so that there is no further liability of the surety upon such bond, the unearned portion of any premium paid to such surety shall be refunded and repaid by the said surety.

Source: L. 79: Entire part R&RE, p. 361, § 7, effective July 1.

Editor's note: This section is similar to former § 10-4-323 as it existed prior to 1979.

10-4-304. Place of deposit. It is lawful for any party of whom a bond, undertaking, or other obligation is required to agree with his surety for the deposit of any moneys and assets for which such surety is or may be held responsible with a bank, savings bank, or safe deposit or trust company authorized by law to do business as such or other depository approved by the court, if such deposit is otherwise proper, for the safekeeping thereof, and in such manner as to prevent the withdrawal of such moneys and assets or any part thereof, without the written consent of such surety or an order of the court made on such notice to such surety as such court may direct, and such agreement shall not in any manner release or change the liability of the principal or sureties as established by the terms of the bond.

Source: L. 79: Entire part R&RE, p. 361, § 7, effective July 1.

Editor's note: This section is similar to former § 10-4-324 as it existed prior to 1979.

10-4-305. Bond part of expense. Any receiver, assignee, guardian, trustee, committee, executor, administrator, curator, or other fiduciary required by law or the order of any court to give a bond or other obligation as such may include, as a part of the lawful expense of executing his trust, such reasonable sum paid a company authorized under the laws of this state so to do for becoming his surety on such bond as may be allowed by the court in which he is required to account, not exceeding one percent per annum on the amount of such bond or other obligation. A party to any action, suit, or proceeding entitled to recover costs in such action, suit, or proceeding shall be allowed and may have taxed and may recover, as costs therein, such sum as said party has paid such a company as premium for executing any bond, recognizance, undertaking, stipulation, or other obligation therein, not exceeding five dollars per annum for each thousand dollars or fraction thereof of the penalty of such bond, recognizance, undertaking, stipulation, or other obligation for each year or part thereof that the same has been in force. The premium so paid shall be taxed by the clerk of the court in which such action, suit, or proceeding is pending, as costs therein, upon production to him of proper receipt for the payment of such premium, which receipt shall be by him filed with the papers in the cause.

Source: L. 79: Entire part R&RE, p. 362, § 7, effective July 1.

Editor's note: This section is similar to former § 10-4-325 as it existed prior to 1979.

PART 4

RATE REGULATION

Editor's note: This part 4 was numbered as article 35 of chapter 72, C.R.S. 1963. The substantive provisions of this part 4 were repealed and reenacted in 1979, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this part 4 prior to 1979, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated.

10-4-401. Purpose - applicability. (1) The purpose of this part 4 is to promote the public welfare by regulating insurance rates to the end that they not be excessive, inadequate, or unfairly discriminatory, to prohibit price-fixing agreements and other anticompetitive behavior by insurers, to promote price competition among insurers, to provide rates that are responsive to competitive market conditions, and to improve the availability and reliability of insurance. For such purposes, the division of insurance of the department of regulatory agencies and the head of the division, the commissioner of insurance, shall be charged with the execution of this part 4.

(2) This part 4 shall apply to all kinds of insurance except:

(a) Reinsurance other than joint reinsurance as provided in section 10-4-411;

(b) Life insurance and annuities regulated under article 7 of this title;

(c) Sickness and accident insurance regulated under parts 1 and 2 of article 16 of this title;

(d) Nonprofit hospital and health services regulated under parts 1 and 3 of article 16 of this title;

(e) Health maintenance organization services regulated under parts 1 and 4 of article 16 of this title;

(f) (Deleted by amendment, L. 2000, p. 465, § 3, effective August 2, 2000.)

(g) Surplus line insurance regulated under article 5 of this title.

(3) The kinds of insurance subject to this part 4 shall be divided into two classes, as follows:

(a) Type I kinds of insurance, regulated by prior filing and approval of rating information, which shall be subject to all provisions of this part 4 unless specifically excluded by the terms of a section. The following kinds of insurance shall be classified as type I:

(I) Workers' compensation and employer's liability incidental thereto for any pure premium rate filed by a rating organization. With regard to a rate filing submitted by a rating organization, the commissioner shall make available to the public, in a manner deemed appropriate by the commissioner, the aggregate loss and payroll data by class code that the rating organization submits with the rate filing. Such data shall not be used for any commercial purpose.

(II) (Deleted by amendment, L. 2000, p. 465, § 3, effective August 2, 2000.)

(III) Assigned risk motor vehicle insurance;

(IV) and (V) Repealed.

(VI) Such other kinds of insurance as the commissioner shall order classified as type I pursuant to the provisions of section 10-4-403 (5).

(b) Type II kinds of insurance, regulated by open competition between insurers, including fire, casualty, inland marine, title, credit, workers' compensation and employer's liability incidental thereto and written in connection therewith for rates filed by insurers, and all other kinds of insurance that are subject to this part 4 and not specified in paragraph (a) of this subsection (3), including the expense and profit components of workers' compensation insurance, which shall be subject to all the provisions of this part 4 except for sections 10-4-405 and 10-4-406. Type II insurers shall file rating data, as provided in section 10-4-403, with the commissioner; except that credit life and credit accident and health insurers shall file schedules of premium rates pursuant to sections 10-10-109 and 10-10-110. A rate filing summary for a type II kind of insurance subject to this part 4, except for workers' compensation insurance, shall be posted on the division's website in order to provide notice to the public. The public notice shall include the rate standards that apply pursuant to section 10-4-403 (1). Nothing in this section shall be construed to limit the right of the public to inspect a rate filing and any supporting information pursuant to part 2 of article 72 of title 24, C.R.S., or to impair the commissioner's ability to review rates and determine that the rates are not excessive, inadequate, or unfairly discriminatory.

(4) Except for type I kinds of insurance as defined in paragraph (a) of subsection (3) of this section, prior approval of rates, schedules of rates, rating plans, rating classifications and territories, rating rules, and rate manuals with the commissioner, or his prior approval thereof, shall not be required. In lieu thereof, the provisions of paragraph (b) of subsection (3) of this section and sections 10-4-413, 10-4-414, and 10-4-418 regarding the availability of such items, the review thereof, and hearings and judicial review thereof are applicable.

(5) Rate filings for insurance subject to this part 4 shall be filed electronically in a format made available by the division, unless exempted by rule for an emergency situation as determined by the commissioner.

Source: L. 79: Entire part R&RE, p. 362, § 8, effective July 1. **L. 81:** (3)(a)(V) repealed and (3)(b) amended, pp. 563, 562, §§ 3, 1, effective July 1. **L. 86:** (2)(g), (3)(b), and (4) amended, p. 579, § 2, effective July 1. **L. 87:** (2)(g) amended, p. 427, § 6, effective May 1; (3)(a)(IV) repealed, p. 439, § 10, effective May 22. **L. 90:** (3)(a)(I) amended, p. 558, § 15, effective July 1. **L. 91:** (3)(a)(I) and (3)(b) amended, p. 1194, § 1, effective April 11. **L. 92:** (2)(f) amended, p. 1557, § 56, effective May 20; (2)(d) and (2)(e) amended, p. 1724, § 7, effective July 1. **L. 2000:** (2)(f) and (3) amended, p. 465, § 3, effective August 2. **L. 2006:** (2)(c) amended, p. 1490, § 12, effective June 1. **L. 2007:** (3)(b) amended and (5) added, p. 2003, § 1, effective January 1, 2008. **L. 2010:** (3)(b) amended, (HB 10-1220), ch. 197, p. 854, § 17, effective July 1; (3)(a)(I) amended, (SB 10-112), ch. 52, p. 196, § 2, effective August 11.

Editor's note: This section is similar to former §§ 10-4-301, 10-4-302, and 10-4-401 as they existed prior to 1979.

Cross references: For the legislative declaration contained in the 2000 act amending subsections (2)(f) and (3), see section 1 of chapter 135, Session Laws of Colorado 2000.

10-4-402. Definitions. As used in this part 4, unless the context otherwise requires:

(1) "Advisory organization" means every group, association, or other organization of insurers, whether located within or outside this state, which prepares policy forms or assists insurers which make their own rates or rating organizations in rate-making by the collection and furnishing of loss or expense statistics or by the submission of recommendations, but which does not make rates under this part 4. "Advisory organization" does not include a joint underwriting association, any actuarial or legal consultant, an insurer or insurers under common control or management, or their employees or managers.

(1.3) "Classification system" or "classification" means the plan, system, or arrangement for recognizing differences in exposure to hazards among industries, occupations, or operations of insurance policyholders.

(1.4) "Competitive market" means a market which has not been found to be noncompetitive pursuant to section 10-4-403 (5).

(1.5) "Expenses" means that portion of any rate attributable to acquisition, field supervision, and collection expenses, general expenses, and taxes, licenses, and fees.

(1.6) "Loss trending" means any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

(2) "Member" means an insurer who participates or is entitled to participate in the management of a rating, advisory, or other organization.

(2.3) "Noncompetitive market" means a market for which there is a ruling in effect pursuant to section 10-4-403 (5) that a reasonable degree of competition does not exist.

(2.4) "Pure premium rate" means that portion of the rate which represents the loss cost per unit of exposure, including loss adjustment expenses.

(3) "Rating organization" means every person, other than an admitted insurer, which has as its object or purpose the making of pure premium rates, rating plans, or rating systems. Two or more admitted insurers, other than insurers having a common ownership or operating in this state under common management or control, which act in concert for the purpose of making pure premium rates, rating plans, or rating systems shall be deemed to be a rating organization unless they operate within the specific authorizations contained in sections 10-4-404, 10-4-409, 10-4-411, and 10-4-412. No single insurer, joint underwriting association, actuarial or legal consultant, insurer or insurers under common control or management, or their employees or managers shall be deemed to be a rating organization.

(3.5) "Stacking" means aggregating, combining, multiplying, or pyramiding limits of separate policies providing uninsured and underinsured motorist coverage as provided in section 10-4-609.

(4) "Subscriber" means an insurer which is furnished, at its request: With rates and rating manuals by a rating organization of which it is not a member; or with advisory services by an advisory organization of which it is not a member.

Source: L. 79: Entire part R&RE, p. 363, § 8, effective July 1. **L. 91:** Entire section amended, p. 1194, § 2, effective April 11. **L. 92:** (3.5) added, p. 1758, § 1, effective June 5.

Editor's note: This section is similar to former § 10-4-401 as it existed prior to 1979.

10-4-403. Standards for rates - competition - procedure - requirement for independent actuarial opinions regarding 1991 legislation. (1) Rates shall not be excessive, inadequate, or unfairly discriminatory. The following rate standards shall apply:

(a) Rates are excessive if they are likely to produce a long run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered.

(b) Concerning inadequacy, rates are not inadequate unless clearly insufficient to sustain projected losses and expenses, or the use of such rates, if continued, will tend to create a monopoly in the market.

(c) Concerning unfair discrimination, unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy. Additionally, the provisions of section 10-3-1104 (1)(f) shall apply.

(2) (a) In determining whether rates comply with the excessiveness standard, the inadequacy standard, and the unfair discrimination standard, the following criteria shall apply:

(I) Concerning basic factors in rates, due consideration shall be given to past and prospective loss and expense experience, to catastrophe hazards and contingencies, to events or trends, to loadings for leveling premium rates over time or for dividends or savings to be allowed or returned by insurers to their policyholders, members, or subscribers, and to all other relevant factors, including judgment;

(II) Concerning expenses, the expense provisions included in the rates to be used by an insurer shall reflect the operating methods of the insurer and, so far as it is credible, its own actual and anticipated expenses experience;

(III) Concerning profits, the rate shall contain provisions for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of profit, consideration should be given to all investment income attributable to premiums and the reserves associated with those premiums.

(b) In setting rates, insurers shall consider past and prospective loss experience and catastrophic hazards, if any, solely within the state of Colorado. However, if there is insufficient experience within Colorado upon which a rate can be based, the insurer may consider experiences within any other state or states which have a similar cost of claim and frequency of claim experience as the state of Colorado; and, if insufficient experience is available, the insurer may use a countrywide experience. The insurer, in its rate filing or in its records, shall expressly state and describe what rate experience it is using, and for Colorado business other than workers' compensation insurance, the insurer shall specify the state or states from which experiences were drawn and the considerations used in setting the rates. In considering experience outside the state of Colorado, as much weight as possible shall be given to the Colorado experience. The rates shall allow a reasonable margin for profit, as allowed in subparagraph (III) of paragraph (a) of this subsection (2), and contingencies.

(2.1) (a) In setting rates for medical malpractice insurance, rates shall not be excessive or inadequate, as defined in this section, nor shall they be unfairly discriminatory. No rate shall be

held to be excessive unless such rate is unreasonably high for the insurance provided and a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable. No rate shall be held to be inadequate unless such rate is unreasonably low for the insurance provided and the continued use of such rate endangers the solvency of the insurer using the same, or unless such rate is unreasonably low for the insurance provided and the use of rate by the insurer using the same has, or if continued will have, the effect of destroying competition or creating a monopoly.

(b) In setting rates, medical malpractice insurers shall consider past and prospective loss experience and catastrophic hazards, if any, solely within the state of Colorado. However, if there is insufficient experience within Colorado upon which a rate can be based, the insurer may consider experiences within any other state or states which have a similar cost of claim and frequency of claim experience as the state of Colorado; and, if insufficient experience is available, the insurer may use a nationwide experience. The insurer, in its rate filing or in its records, shall expressly state and describe what rate experience it is using, specifying the state or states from which experiences were drawn and the considerations used in setting the rates. In considering experience outside the state of Colorado, as much weight as possible shall be given to the Colorado experience. The rates shall allow a reasonable margin for profit and contingencies, including dividends, savings, or unearned premium deposits allowed or returned by insurers to their policyholders, members, or subscribers. In determining profits, the insurer shall consider investment income from unearned premium reserves and reserves for incurred losses and incurred but not reported losses.

(c) Medical malpractice insurers shall specify in their rate filings and shall consider and support the evaluation with an analysis and opinion of a qualified property and casualty actuary, and the commissioner as a result of such filing or upon his own motion may also consider, the impact of the following on medical malpractice rates:

(I) Tort reform legislation;

(II) Risk management activities;

(III) Underwriting standards and practices;

(IV) Any other activity designed to reduce rates or rate increases or the cost of administration and determination of claims.

(d) and (e) Repealed.

(2.5) Notwithstanding any provision of law to the contrary, any insurer licensed to sell motor vehicle insurance within the state of Colorado may offer a reduction in premiums if the claims experience subsequent to the enactment of section 42-4-237, C.R.S., so warrants.

(3) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(4) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions or both. Such standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses.

(4.6) Repealed.

(5) Under the commissioner's power to review rates of all companies, if he determines, after a hearing and on the basis of findings of fact and conclusions, that, with respect to any territory or to any kind, subdivision, or class of insurance, competition is either insufficient to assure that rates will not be excessive, or so conducted as to be destructive of competition or detrimental to the solvency of insurers, he shall order that the rates for such insurance or territory shall be regulated as type I kinds of insurance as defined in section 10-4-401 (3)(a). Such order shall have a specified duration of not more than one year but may be renewed by the commissioner upon appropriate findings of fact, conclusions, and order.

(6) The commissioner shall require an independent actuarial opinion that the best estimate of the impact of the reforms to the workers' compensation system enacted in Senate Bill 91-218 during the first regular session of the fifty-eighth general assembly have been incorporated in any workers' compensation rate change filed with the commissioner until July 1, 1994.

(7) This section shall not apply to insurers providing coverage to exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 79: Entire part R&RE, p. 364, § 8, effective July 1. **L. 86:** (2) amended, p. 579, § 3, effective July 1. **L. 87:** (2.5) added, p. 1533, § 4, effective May 7. **L. 88:** (2.1) and (4.6) added, p. 623, § 2 effective July 1. **L. 91:** (1), (2), and (2.1) amended, p. 1196, § 3, effective April 11; (6) added, p. 1337, § 53, effective July 1. **L. 93:** (2.1)(e) added, p. 1920, § 3, effective July 1. **L. 94:** (2.5) amended, p. 2545, § 17, effective January 1, 1995. **L. 99:** (7) added, p. 386, § 2, effective January 15, 2000. **L. 2000:** (2.1)(d) and (4.6) repealed, p. 465, § 4, effective August 2. **L. 2006:** (2)(b) and (2.1)(b) amended, p. 1430, § 2, effective August 7.

Editor's note: (1) This section is similar to former §§ 10-4-303 and 10-4-402 as they existed prior to 1979.

(2) Subsection (2.1)(e)(II) provided for the repeal of subsection (2.1)(e), effective July 1, 1996. (See L. 93, p. 1920.)

Cross references: For the legislative declaration contained in the 2000 act repealing subsections (2.1)(d) and (4.6), see section 1 of chapter 135, Session Laws of Colorado 2000.

10-4-404. Rate administration. (1) The commissioner shall promulgate rules and regulations which shall require each insurer to record and report its loss and expense experience and such other data, including reserves, as may be necessary to determine whether rates comply with the standards set forth in section 10-4-403. Every insurer or rating organization shall provide such information and in such form as the commissioner may require. No insurer shall be required to record or report its loss or expense experience on a classification basis that is inconsistent with the rating system used by it. The commissioner may designate one or more rating organizations or advisory organizations to assist him in gathering and in compiling such experience and data. No insurer shall be required to record or report its experience to a rating organization unless it is a member of such organization.

(2) (a) The commissioner may require that the annual report and any such supplemental report which contains information of a company's loss and loss adjustment reserves be

accompanied by an opinion signed and sworn to by a qualified and independent actuary verifying that, within the nine months prior to the submission of the report, the actuary has conducted a review and analysis of the insurance company's loss and loss adjustment reserves and the reserves are computed in accordance with accepted loss reserving standards and are fairly stated in accordance with sound loss reserving principles.

(b) For purposes of the requirements of this section, a qualified actuary shall be an associate or fellow of the casualty actuarial society and shall be independent of the company whose reserves the actuary has reviewed and analyzed and which is submitting the sworn actuarial certificate.

(3) Any insurer who fails to comply with the terms of this section shall pay a civil penalty of ten thousand dollars and a fine of two hundred dollars for every day thereafter until the insurer complies with this section.

(4) It is the duty of the commissioner to maintain for at least six years by carrier all reports submitted by insurers pursuant to rules and regulations promulgated by the commissioner under this section. The commissioner shall consider these reports in determining the appropriateness of premium rates for various types of insurance in this state.

(5) In order to make the administration of rate regulatory laws uniform, the commissioner and every insurer and rating organization may exchange information and loss experience data.

(6) The commissioner shall promulgate regulations to effect rate reductions or credits for insureds who implement plans pursuant to article 14.5 of title 8, C.R.S.

(7) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 79: Entire part R&RE, p. 365, § 8, effective July 1. **L. 81:** (4) amended, p. 533, § 1, effective April 30. **L. 86:** (5), (6), and (7) added, p. 558, § 20, effective July 1. **L. 89:** (7) repealed, p. 442, § 27, effective July 1. **L. 90:** Entire section R&RE, p. 618, § 1, effective April 5; (6) RC&RE, p. 616, § 1, effective April 12. **L. 97:** (4) amended, p. 1477, § 21, effective June 3. **L. 99:** (7) added, p. 387, § 3, effective January 15, 2000.

Editor's note: (1) This section is similar to former § 10-4-314 as it existed prior to 1979.

(2) Subsection (6) was numbered as subsection (7) in HB 90-1212 but was renumbered on revision for proper placement in the section as repealed and reenacted by HB 90-1214.

10-4-404.5. Rating plans - property and casualty type II insurers - rules. (1) The commissioner may promulgate rules for type II insurers that establish reasonable standards for rating plans, including experience rating plans, schedule rating plans, and expense reduction plans, and that are designed to modify rates in the development of premiums for individual risks insured in the property and casualty insurance market. Such rules may permit recognition of expected differences in loss and expense characteristics and shall be designed so that such plans are reasonable and equitable in their application and are not unfairly discriminatory. Such rules shall not prevent the development of new rating methods that would otherwise comply with this part 4. The rules may establish maximum charges against and credits to the experience rating of

an insured that may result from the application of a rating plan. The rules may encourage the use of loss control programs, safety programs, and other methods of risk management and may require insurers to maintain documentation of the basis for the charges and credits applied under any plan. The rules may also require the rating plans to include merit rating to the extent feasible.

(2) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 88: Entire section added, p. 402, § 1, effective April 29. **L. 99:** Entire section amended, p. 387, § 4, effective January 15, 2000.

10-4-404.6. Legislative declaration - obtaining information of impact of changes in the civil justice system. (Repealed)

Source: L. 89: Entire section added, p. 452, § 1, effective June 1.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 1990. (See L. 89, p. 452.)

10-4-405. Filing of rating information - certain coverages. (1) With respect to type I kinds of insurance as defined in section 10-4-401 (3)(a), every insurer shall file with the commissioner every manual of classifications, rules, and rates, every rating plan, and every modification of any of the foregoing which it proposes to use in this state.

(2) (a) Every filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated. Filings regarding workers' compensation insurance rates shall be filed on or before August 1 of any calendar year. When a filing is not accompanied by the information upon which the insurer supports the filing and the commissioner does not have sufficient information to determine whether the filing meets the requirements of this part 4, he shall, within fifteen days after the date of filing, require the insurer to furnish the information upon which it supports the filing, and in such event the waiting period provided for in section 10-4-406 (2) shall commence as of the date such information is furnished.

(b) The information furnished in support of a filing may include: The experience or judgment of the insurer or rating organization making the filing; its interpretation of any statistical data it relied upon; the experience of other insurers or rating organizations; or any other factors which the insurer or rating organization deems relevant.

(3) A filing and any supporting information shall be open to public inspection at the division of insurance.

(4) An insurer may satisfy its obligation to make such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings and by authorizing the commissioner to accept such filings in its behalf; but nothing contained in this title shall be construed as requiring any insurer to become a member of, or a subscriber to, any rating organization.

(5) Upon the written application of the insured, stating his reasons therefor, filed with and approved by the commissioner, a rate in excess of that provided by filing, otherwise applicable, may be used on any specific risk, and such application shall not be subject to any of the provisions of section 10-4-406.

Source: L. 79: Entire part R&RE, p. 366, § 8, effective July 1. **L. 2004:** (2)(a) amended, p. 395, § 1, effective August 4.

Editor's note: This section is similar to former § 10-4-304 as it existed prior to 1979.

10-4-406. Review of filings - certain coverages. (1) Upon receipt of filings required under the provisions of section 10-4-405 (1), the commissioner shall review, or cause to be reviewed, the same as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this part 4.

(2) A filing which the commissioner has placed on file for public inspection, shall so remain on file for fifteen days (counting such filing date as the first day of such public inspection period) and shall not be approved, disapproved, or become effective during such fifteen-day period except after a public hearing. If not theretofore approved or disapproved after a public hearing thereon, or affirmatively approved or disapproved by the commissioner on the sixteenth day after the filing was so placed on file for public inspection, the filing shall be deemed approved as of 12:01 a.m. on such sixteenth day, unless within such fifteen-day period the commissioner concludes it to be in the public interest to hold a public hearing to determine whether the filing meets the requirements of this part 4 and gives notice of such hearing to the insurer or rating organization that made the filing, in which case the effectiveness of the filing shall be subject to the further order of the commissioner.

(2.5) For any filing made pursuant to section 10-4-405 for workers' compensation and employer's liability insurance incidental thereto and written in connection therewith, and where the commissioner determines that it is necessary to use the services authorized in subsection (3.5) of this section, the commissioner shall have a reasonable time not to exceed sixty days to review or inspect the filing after it is determined to be complete and before the filing shall be considered placed on file pursuant to subsection (2) of this section. The commissioner shall place on file for public inspection the results of any review or examination performed pursuant to subsection (3.5) of this section.

(3) An insurer or rating organization may, at the time it makes a filing with the commissioner, request a public hearing thereon. In such event the commissioner shall forthwith place the filing on file in his office for public inspection, and shall give notice of the hearing, and shall otherwise hold and conduct the hearing as provided in section 10-4-407; and the effectiveness of the filing shall be subject to the commissioner's order made following the hearing.

(3.5) If the commissioner determines that it is reasonably necessary, the commissioner may cause the filing to be reviewed or examined by actuaries, accountants, insurance experts, or any other person at the discretion of the commissioner. The reasonable costs of any such review or examination shall be paid by the rating organization, advisory organization, or group, association, or insurer submitting the filing for approval.

(4) (a) If any such filing results in a change in premium rate as to assigned risk motor vehicle insurance, the commissioner shall, coincidentally with placing the filing on file in his office for public inspection as provided in this section, inform two established news agencies having offices at Denver thereof by mailing, postage prepaid, to each of said news agencies a notice of such filing. Such notice shall read as follows:

Notice of assigned risk motor vehicle insurance rate filing, pursuant to section 10-4-406 (4), Colorado Revised Statutes, is hereby given by the commissioner of insurance that a rate change has been filed by:

Name of insurance company

Type of property affected

Type of insurance coverage

Nature of rate change
Date of filing

Dated and signed at Denver, Colorado, this ( ) day of (month), 20....

By: .....

Commissioner of Insurance

The commissioner shall certify in writing as to the mailing of the aforesaid notices to such news agencies, and a copy of the certificate shall be made part of the commissioner's records pertaining to such filings. The effectiveness of any such filing or action of the commissioner relative thereto shall not be affected by failure of the commissioner so to inform any particular news agency.

(b) It is the intent of this subsection (4) that the sending of said notice is the responsibility of the commissioner and not of the company or rating organization requesting the rate change.

(5) (a) If the commissioner approves a filing, he or she shall give prompt notice thereof to the insurer or rating organization that made the filing. The filing shall become effective upon such subsequent date as may be satisfactory to the commissioner and the insurer or rating organization that made the filing; except that rates for workers' compensation insurance shall become effective on January 1 unless the commissioner, upon application, makes a finding upon good cause shown that a later date is necessary or appropriate for the implementation of such filing.

(b) If the filing is deemed approved in the absence of affirmative action by the commissioner, as provided in subsection (2) of this section, it shall become effective upon such subsequent date as may be satisfactory to the commissioner and the insurer or rating organization that made the filing; except that rates for workers' compensation insurance shall become effective on January 1 unless the commissioner, upon application, makes a finding upon

good cause shown that a later date is necessary or appropriate for the implementation of such filing.

(c) If the commissioner disapproves a filing, he shall promptly give notice of such action to the insurer or rating organization that made the filing, stating the respects in which the filing does not meet the requirements of this part 4.

Source: L. 79: Entire part R&RE, p. 366, § 8, effective July 1. **L. 85:** (5) amended, p. 381, § 2, effective April 17. **L. 91:** (1) amended and (2.5) and (3.5) added, p. 1198, § 4, effective April 11; (2.5) amended, p. 1909, § 11, effective June 1. **L. 2004:** (5)(a) and (5)(b) amended, p. 395, § 2, effective August 4.

Editor's note: This section is similar to former § 10-4-305 as it existed prior to 1979.

10-4-407. Hearings. (1) If, pursuant to section 10-4-406 (2), the commissioner determines to hold a public hearing as to a filing or holds such a public hearing pursuant to request therefor under section 10-4-406 (3), he shall give written notice thereof to the rating organization or insurer that made the filing, shall hold such hearing within thirty days after commencement of the public inspection period provided for in section 10-4-406 (3), and, not less than ten days prior to the date of the hearing, he shall give written notice of the hearing to the insurer or rating organization that made the filing. The commissioner may also give advance public notice of such hearing by publication of notice in one or more daily newspapers of general circulation in this state.

(2) If the commissioner's order disapproves the filing, the rate change shall not be placed into effect. If the commissioner's order approves the filing or any portion thereof, the approved rate filing shall become effective upon such subsequent date as may be satisfactory to the insurer or rating organization that made the filing; except that rates for workers' compensation insurance shall become effective on January 1 unless the commissioner, upon application, makes a finding upon good cause shown that a later date is necessary or appropriate for the implementation of such filing.

(3) Any person aggrieved by the approval by the commissioner of a rate filing may make written application to the commissioner for a hearing thereon, and such application shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing, he shall hold a hearing as provided in sections 24-4-102 to 24-4-107, C.R.S.

(4) Any insurer or rating organization aggrieved by an order or decision of the commissioner made without a hearing may, within thirty days after notice of the order or decision to the insurer or rating organization, make written application to the commissioner for a hearing thereon. The commissioner shall hold a hearing as provided in sections 24-4-102 to 24-4-107, C.R.S. Within fifteen days after such hearing, the commissioner shall affirm, reverse, or modify his previous action, specifying his reasons therefor. Pending such hearing and decision thereon, the commissioner may suspend or postpone the effective date of his previous action.

(5) Hearings held under this part 4 shall be held by the commissioner or his designee. Any final action of the commissioner pursuant to this part 4 shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 79: Entire part R&RE, p. 368, § 8, effective July 1. **L. 85:** (2) amended, p. 382, § 3, effective April 17. **L. 86:** (5) added, p. 580, § 4, effective July 1. **L. 91:** (2) amended, p. 1199, § 5, effective April 11. **L. 92:** (5) amended, p. 1557, § 57, effective May 20. **L. 2004:** (2) amended, p. 396, § 3, effective August 4.

Editor's note: This section is similar to former §§ 10-4-318 and 10-4-403 as they existed prior to 1979.

10-4-408. Rating organization - study of workers' compensation rates - premium reductions - adoption of rules. (1) A corporation, an unincorporated association, a partnership, or an individual, whether located within or outside this state, may make application to the commissioner for a license as a rating organization for such kinds of insurance or subdivisions thereof as are specified in its application and shall file therewith:

(a) A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business;

(b) A list of its members and subscribers;

(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served; and

(d) A statement of its qualifications as a rating organization.

(2) If the commissioner finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or its certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business conform to the requirements of law, the commissioner shall issue a license specifying the kinds of insurance or subdivisions thereof for which the applicant is authorized to act as a rating organization. Every such application shall be granted or denied in whole or in part by the commissioner within sixty days after the date of its filing. Licenses issued pursuant to this section shall remain in effect for three years unless sooner suspended or revoked by the commissioner. The fee for said license shall be twenty-five dollars; except that the commissioner by rule or as otherwise provided by law may reduce the amount of the fee if necessary pursuant to section 24-75-402 (3), C.R.S., to reduce the uncommitted reserves of the fund to which all or any portion of the fee is credited. After the uncommitted reserves of the fund are sufficiently reduced, the commissioner by rule or as otherwise provided by law may increase the amount of the fee as provided in section 24-75-402 (4), C.R.S.

(3) Licenses issued pursuant to this section may be suspended or revoked by the commissioner, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this section.

(4) Every rating organization shall notify the commissioner promptly of every change in:

(a) Its constitution, its articles of agreement or association or its certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business;

(b) Its list of members and subscribers;

(c) The name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such rating organization may be served.

(5) (a) The commissioner shall organize a working group composed of representatives of employer and employee organizations, regulatory agencies, and the insurance industry including,

but not limited to, representatives of businesses insured for worker's compensation in the state of Colorado and an insurance actuary to study issues concerning workers' compensation rates, including, but not limited to, definitions of excessive, inadequate, and discriminatory rates, profits, expenses, and loss-ratio standards for insurance companies, and powers the commissioner should have concerning the rate-setting process.

(b) The commissioner and the working group shall also review the appropriateness of allowing insurance carriers to provide up-front premium discounts as opposed to providing only premium dividends to insureds based on participation in risk-management programs.

(c) The commissioner shall promulgate rules and regulations which establish standards for risk-management services which shall be offered by community, technical, or local district colleges or by insurance carriers offering workers' compensation insurance pursuant to articles 40 to 47 of title 8, C.R.S. Business entities which accept such risk-management services and comply with the standards established by the commissioner shall be entitled to a premium dividend if any such business entity's loss experience under the risk-management program indicates such premium dividend is warranted. In developing such rules and regulations, the commissioner shall consider the information developed by the workers' compensation cost-containment board. In such rules and regulations, the commissioner shall require insurance carriers to inform policyholders in a clear and conspicuous manner of the availability of cost containment certification by the workers' compensation cost containment board pursuant to section 8-14.5-107, C.R.S.

(d) The commissioner shall promulgate rules and regulations which establish that all insurance companies in this state offering workers' compensation insurance pursuant to articles 40 to 47 of title 8, C.R.S., shall provide a premium differential on all policies when the policyholder has selected an authorized treating physician or physicians. Such premium differential shall be clearly stated to all policyholders in an appropriate communication medium on an annual basis.

(e) On or before October 1, 1994, the commissioner shall promulgate rules which establish, for purposes of section 8-44-115, C.R.S., standards for determining:

(I) When a motor vehicle accident has not been caused, wholly or in part, by an employee or the employer of such employee;

(II) A loss limitation to be included in the calculation of workers' compensation insurance experience modifications when a motor vehicle accident has not been caused, wholly or in part, by an employee or the employer of such employee;

(III) The distribution, among workers' compensation classifications, of any loss remaining after deduction of the loss limitation established under subparagraph (II) of this paragraph (e); and

(IV) (A) When the use of a motor vehicle is an integral part of an employer's business.

(B) Rules promulgated pursuant to this subparagraph (IV) shall be based on the job classification system for workers' compensation insurance in use on January 1, 1994.

Source: L. 79: Entire part R&RE, p. 369, § 8, effective July 1. **L. 90:** (5) added, p. 616, § 2, effective April 12. **L. 91:** (5)(c) amended, p. 1354, § 3, effective April 20. **L. 92:** (5)(c) amended, p. 1817, § 2, effective July 1. **L. 94:** (5)(e) added, p. 1367, § 2, effective October 1. **L. 97:** (5)(a) amended, p. 1478, § 22, effective June 3. **L. 98:** (2) amended, p. 1327, § 29, effective June 1.

Editor's note: This section is similar to former § 10-4-306 as it existed prior to 1979.

10-4-409. Rates furnished - cooperation among organizations. (1) Subject to rules and regulations which are approved by the commissioner as reasonable, each rating organization shall permit any insurer, not a member, to be a subscriber to its rating services for any kind of insurance or subdivision thereof for which it is authorized to act as a rating organization. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers. The reasonableness of any rule or regulation in its application to subscribers or the refusal of any rating organization to admit an insurer as a subscriber, at the request of any subscriber or any such insurer, shall be reviewed by the commissioner at a hearing held upon at least ten days' written notice to such rating organization and to such subscriber or insurer. If the commissioner finds that such rule or regulation is unreasonable in its application to subscribers, he shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within thirty days after it is made, the insurer may request a review by the commissioner as if the application has been rejected. If the commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, he shall order the rating organization to admit the insurer as a subscriber. If he finds that the action of the rating organization is justified, he shall make an order affirming its action.

(2) No rating organization shall adopt any rule the effect of which would prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

(3) Cooperation among rating organizations or among rating organizations and insurers in rate-making or in other matters within the scope of this part 4 is authorized, if the rates resulting from such cooperation are subject to all the provisions of this part 4 which are applicable to rates generally. The commissioner may review such cooperative activities and practices and if, after a hearing, he finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this part 4, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this part 4 and requiring the discontinuance of such activity or practice.

Source: L. 79: Entire part R&RE, p. 369, § 8, effective July 1.

Editor's note: This section is similar to former § 10-4-307 as it existed prior to 1979.

10-4-410. Advisory organizations. (1) Every advisory organization shall file with the commissioner a copy of its constitution, its articles of agreement or association or its certificate of incorporation, and its bylaws, rules, and regulations governing its activities, a list of its members, the name and address of a resident of this state upon whom notices or orders of the commissioner or process issued at his direction may be served, and an agreement that the commissioner may examine such advisory organization in accordance with the provisions of section 10-4-414.

(2) If, after hearing, the commissioner finds that the furnishing of such information or assistance involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of this part 4, he may issue a written order specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this part 4 and requiring the discontinuance of such act or practice.

Source: L. 79: Entire part R&RE, p. 370, § 8, effective July 1.

Editor's note: This section is similar to former § 10-4-311 as it existed prior to 1979.

10-4-411. Joint underwriting. (1) Every group, association, or other organization of insurers which engages in joint reinsurance or joint underwriting shall be subject to regulation with respect thereto as provided in this part 4.

(2) If, after a hearing, the commissioner finds that any activity or practice of any such group, association, or other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this part 4, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this part 4 and requiring the discontinuance of such activity or practice.

Source: L. 79: Entire part R&RE, p. 370, § 8, effective July 1.

Editor's note: This section is similar to former § 10-4-312 as it existed prior to 1979.

10-4-412. Assigned risk motor vehicle insurance. (1) The commissioner may, after consultation with the insurers licensed to write motor vehicle insurance in this state, establish or approve a reasonable plan, and rules governing the same, for the equitable apportionment among such insurers of applicants for such insurance who are in good faith entitled to but are unable to procure insurance through ordinary methods, and, when such plan has been approved, all such insurers shall subscribe thereto and shall participate therein. Any applicant for such insurance, any person insured under such plan, and any insurer affected may appeal to the commissioner from any ruling or decision of the manager or committee designated to operate such plan.

(2) If an insurer admitted to transact motor vehicle insurance fails to subscribe to the plan or to any amendments thereto or fails to comply with the rules of the plan, the commissioner shall give ten days' written notice to such insurer to so subscribe or so comply. If such insurer fails to comply with such notice, the commissioner, after hearing, may suspend the certificate of authority of such insurer to transact insurance business in this state until such insurer so complies.

Source: L. 79: Entire part R&RE, p. 371, § 8, effective July 1.

Editor's note: This section is similar to former § 10-4-316 as it existed prior to 1979.

10-4-413. Records required to be maintained. (1) Every insurer, rating organization, or advisory organization and every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance shall maintain reasonable records, of the type

and kind reasonably adapted to its method of operation, of its experience or the experience of its members and of the data, statistics, or information collected or used by it in connection with the rates, rating plans, rating systems, underwriting rules, policy or bond forms, surveys, or inspections made or used by it, so that such records will be available at all reasonable times to enable the commissioner to determine whether such organization, insurer, group, or association and, in the case of an insurer or rating organization, every rate, rating plan, and rating system made or used by it complies with the provisions of this part 4 applicable to it. The maintenance of such records in the office of a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization to the extent that the insurer uses the rates, rating plans, rating systems, or underwriting rules of such organization. Such records shall be maintained in an office within this state or shall be made available for examination or inspection by the commissioner at any time, upon reasonable notice.

(2) All records of any such organization or individual insurer dealing with workers' compensation and employer's liability insurance incidental thereto and written in connection therewith shall be subject to the requirements of article 44 of title 8, C.R.S., concerning the filing of its system of rates.

Source: L. 79: Entire part R&RE, p. 371, § 8, effective July 1. **L. 90:** (2) amended, p. 558, § 16, effective July 1.

10-4-414. Examinations.

(1) Repealed.

(2) The commissioner may, at any reasonable time, make or cause to be made an examination of every admitted insurer transacting any class of insurance to which the provisions of this part 4 are applicable to ascertain whether such insurer and every rate and rating system used by it for every such class of insurance complies with the requirements and standards of this title applicable thereto. Such examination need not be a part of a periodic general examination participated in by representatives of more than one state.

(3) The officers, managers, agents, and employees of any such organization, group, association, or insurer may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation, together with all data, statistics, and information of every kind and character collected or considered by such organization, group, association, or insurer in the conduct of the operations to which such examination relates.

(4) The commissioner may conduct such examination on the basis of concern for an insurer's solvency or the complaint of a person claiming to be aggrieved or to ascertain compliance by insurers and rating organizations with the requirements of this part 4.

(5) Filed reports on examinations shall be available for public inspection at the division of insurance.

(6) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 79: Entire part R&RE, p. 372, § 8, effective July 1. **L. 99:** (6) added, p. 387, § 5, effective January 15, 2000. **L. 2004:** (1) repealed, p. 1063, § 13, effective July 1.

Editor's note: This section is similar to former § 10-4-313 as it existed prior to 1979.

10-4-415. Prohibition against anticompetitive behavior. (1) (a) No insurer or rating organization shall monopolize or attempt to monopolize, or combine or conspire with any other person to monopolize, in any territory, the business of insurance of any kind, subdivision, or class thereof.

(b) No insurer or rating organization shall agree with any other insurer or rating organization to charge or adhere to any rate, although insurers and rating organizations may continue to exchange statistical information.

(c) No insurer or rating organization shall make any agreement with any other insurer, rating organization, or other person to restrain trade.

(d) No insurer or rating organization shall make any agreement with any other insurer, rating organization, or other person the effect of which may be substantially to lessen competition in any territory or in any kind, subdivision, or class of insurance.

(e) No insurer may acquire or retain any capital stock or assets of, or have any common management with, any other insurer if the effect of such acquisition, retention, or common management may be substantially to lessen competition in any territory or in any kind, subdivision, or class of insurance.

(f) No insurer or rating organization shall make any agreement with any other insurer or rating organization to refuse to deal with any person in connection with the sale of insurance.

(g) No rating organization or member or subscriber thereof shall interfere with the right of any insurer to make its rates independently of such rating organization or to charge rates different from the rates made by such rating organization.

(h) No member of or subscriber to a rating organization shall refuse to do business with, or prohibit or prevent the payment of commissions to, any licensed agent or broker on the ground that such agent or broker does business with an insurer which makes its rates, or any portion thereof, independently of such rating organization.

(i) Nothing in this part 4 shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization, or as preventing any insurer, while a member of or subscriber to a rating organization, from making its own rates for any kind, subdivision, or class of insurance, for which it does not elect to authorize the rating organization to act on its behalf.

(j) Any insurer which is a member of or subscriber to a rating organization may make its own rates for any kind, subdivision, or class of insurance. No rating organization shall have authority to act on behalf of any insurer which is a member of or subscriber to such rating organization except as authorized in writing by such member or subscriber, which authority may be supplemented, modified, or revoked, in whole or in part, at any time by such member or subscriber at its option.

(k) No rating organization shall have or adopt any rule or exact any agreement, or formulate or engage in any program, the effect of which would be to require any member, subscriber, or other insurer to utilize some or all of its services, or to adhere to its rates, rating plans, rating systems, underwriting rules, or policy forms, or to prevent any insurer from acting independently.

(2) (a) The commissioner, through the attorney general, and any person injured in his business or property by reason of anything forbidden in subsection (1) of this section may maintain an action to enjoin any violation of such subsection (1).

(b) Any person injured in his business or property by reason of anything forbidden in subsection (1) of this section may maintain an action and shall be able to recover punitive damages not to exceed actual monetary loss and expense.

Source: L. 79: Entire part R&RE, p. 372, § 8, effective July 1.

Editor's note: This section is similar to former § 10-4-404 as it existed prior to 1979.

10-4-416. Prohibiting changes in rates or coverages. In any case involving insurance subject to this part 4 on which an insured has prepaid a premium for the issuance of a policy of insurance for a specified policy period, the insurer shall not increase unilaterally, during said policy period, the rate charged nor decrease the coverage benefits provided unless there is a change in risk during the policy term attributable to any act or acts of the insured or the risk to be insured was misrepresented by the insured. This section shall not prohibit cancellation of a policy for any reason otherwise permitted by the policy or by law during an initial policy period of not to exceed sixty days.

Source: L. 79: Entire part R&RE, p. 373, § 8, effective July 1.

Editor's note: This section is similar to former § 10-4-315 as it existed prior to 1979.

10-4-417. False or misleading information. No person or organization shall willfully withhold information from, or knowingly give false or misleading information to, the commissioner, any statistical agency designated by the commissioner, any rating organization, or any insurer which will affect the rates or premiums chargeable under this part 4.

Source: L. 79: Entire part R&RE, p. 374, § 8, effective July 1.

Editor's note: This section is similar to former § 10-4-214 as it existed prior to 1979.

10-4-418. Enforcement procedures - penalties. (1) Any person aggrieved by any rate charged, rating plan, rating system, underwriting rule, policy form, certificate, or contract of insurance or rider followed or adopted by an insurer, advisory organization, or rating organization may request the insurer, advisory organization, or rating organization to review the manner in which the rate, plan, system, rule, form, certificate, or contract or rider has been applied with respect to insurance afforded him. Such request may be made by his authorized representative and shall be written. If the request is not granted within thirty days after it is made, it may be treated as rejected. Any person aggrieved by the action of an insurer, advisory organization, or rating organization in refusing the review requested or in failing or refusing to grant all or part of the relief requested may file a written complaint and request for hearing with the commissioner, specifying the grounds relied upon. If the commissioner finds that probable cause for the complaint does not exist or that the complaint is not made in good faith, he shall

deny the hearing; however, if he finds that the complaint charges a violation of this title and that the complainant would be aggrieved if the violation is proven, he shall proceed as provided in subsection (2) of this section.

(2) (a) If, after examination or inspection of an insurer, rating organization, advisory organization, or group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance, or upon the basis of other information, or upon sufficient complaint as provided in subsection (1) of this section, the commissioner has good cause to believe that such insurer, organization, group, or association, or any rate, rating plan, rating system, underwriting rule, policy form, certificate, contract of insurance or rider, made or used by any such insurer, advisory organization, or rating organization, or proposals thereof made by advisory or rating organizations does not comply with the applicable requirements and standards of this title, he shall, unless he has good cause to believe that such noncompliance is willful, give notice in writing to such insurer, organization, group, or association, stating therein in what manner and to what extent such noncompliance is alleged to exist and specifying therein a reasonable time, not less than ten days thereafter, in which such noncompliance shall be corrected. Notices and filings of underwriting rules required under this section shall be confidential as between the commissioner and the parties.

(b) The commissioner shall not find that a policy form, certificate, or contract of insurance or rider does not comply with the applicable requirements and standards of this title on the ground that it excludes coverage of claims made by a member of a household against another member of the same household. Such exclusions are in conformity with the public policy of this state.

(c) Repealed.

(3) (a) If the commissioner has good cause to believe that such noncompliance is willful or if, within the period prescribed by the commissioner in the notice required by subsection (2) of this section, the insurer, organization, group, or association does not make such changes as may be necessary to correct the noncompliance specified by the commissioner or establish to the satisfaction of the commissioner that such specified noncompliance does not exist, the commissioner may hold a public hearing in connection therewith. Within a reasonable period of time, not less than ten days before the date of such hearing, he shall mail a written notice of the hearing to such insurer, organization, group, or association. The notice given under this subsection (3) shall state in what manner and to what extent noncompliance is alleged to exist and the matters to be considered at such hearing. The hearing shall not include subjects not specified in the notice. The hearing shall be conducted in accordance with section 24-4-105, C.R.S., and the commissioner shall have all the powers granted in said section.

(b) Any insurer, rating organization, advisory organization, or group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance aggrieved by an order or decision of the commissioner made without a hearing may, within thirty days after notice of the order or decision to the corporation, make written application to the commissioner for a hearing thereon. The commissioner shall hold a hearing as provided in the applicable provisions of article 4 of title 24, C.R.S. Within fourteen days after such hearing, the commissioner shall affirm, reverse, or modify his previous action, specifying his reasons therefor.

(4) If, after a hearing pursuant to subsection (3) of this section, the commissioner finds:

(a) That any rate, rating plan, or rating system violates the provisions of this title applicable to it, the commissioner may issue an order to the insurer or rating organization which has been the subject of the hearing, specifying in what respects such violation exists and stating when, within a reasonable period of time, the further use of such rate or rating system by such insurer or rating organization in contracts of insurance made thereafter shall be prohibited. In such order the commissioner may require the excess premium plus a maximum of eighteen percent interest to be refunded to the policyholder. The amount of the refund, plus interest, shall be computed from the effective date of the rate used on the individual policyholder contract to the commencement date of the hearing on the rate. Interest shall be computed as simple interest per annum.

(b) That an insurer, rating organization, advisory organization, or group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance is in violation of the provisions of this title applicable to it, other than the provisions dealing with rates, rating plans, or rating systems, he may issue an order to such insurer, organization, group, or association which has been the subject of the hearing, specifying in what respects such violation exists and requiring compliance within a specified time thereafter;

(c) That any policy form, policy, certificate, contract of insurance or rider, or any portion or any proposal thereof made by advisory or rating organizations contains any provision or style of presentation which is deceptive or misleading or renders its use hazardous to the public or the policyholders or otherwise does not comply with the requirements of law, he may issue an order to such insurer, organization, group, or association which has been the subject of the hearing, prohibiting the further use of any such form in this state;

(d) That the violation of any of the provisions of this title applicable to it by any insurer or rating organization which has been the subject of hearing was willful, he may suspend or revoke, in whole or in part, the certificate of authority of such insurer or the license of such rating organization with respect to the class of insurance which has been the subject matter of the hearing;

(e) That any rating organization has willfully engaged in any fraudulent or dishonest act or practice, he may suspend or revoke, in whole or in part, the license of such organization in addition to any other penalty provided in this title.

(5) In addition to other remedies or penalties provided by law:

(a) The commissioner may suspend or revoke, in whole or in part, the license of any rating organization or the certificate of authority of any insurer which fails to comply with an order of the commissioner within the time limited by such order. The commissioner shall not suspend or revoke the license or certificate of authority for failure to comply with an order until the time prescribed for an appeal therefrom has expired or, if an appeal has been taken, until such order has been affirmed. The commissioner may determine when a suspension or revocation of license or certificate of authority shall become effective. An order of suspension shall remain in effect for the period fixed by the commissioner, unless he modifies or rescinds such suspension or until the order upon which such suspension is based is modified, rescinded, or reversed. No license shall be suspended or revoked except upon a written order of the commissioner, stating his findings, made after a hearing held upon not less than ten days' written notice to such person or organization specifying the alleged violation.

(b) If a failure to comply with an order of the commissioner within the time limited by such order is willful, the rating organization or insurer shall be liable to the state in an amount

not exceeding five thousand dollars for such failure. The commissioner shall collect the amount so payable and may bring a civil action in the name of the people of the state of Colorado to enforce collection. Such penalty may be in addition to the remedy provided in paragraph (a) of this subsection (5). All moneys collected by the commissioner under this paragraph (b) shall be paid into the general fund of the state of Colorado.

(6) Any findings, determination, rule, ruling, or order made by the commissioner shall be subject to judicial review by the court of appeals, and proceedings on review shall be in accordance with the provisions of section 24-4-106 (11), C.R.S.

(7) This section shall apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section, that the commissioner determines to be anticompetitive, as described in section 10-4-415.

Source: L. 79: Entire part R&RE, p. 374, § 8, effective July 1. **L. 86:** (1), (2), and (4)(c) amended, p. 580, § 5, effective July 1. **L. 91:** (4)(a) amended, p. 1199, § 6, effective April 11. **L. 92:** (6) amended, p. 1558, § 58, effective May 20; (2)(c) added, p. 1758, § 2, effective June 5. **L. 99:** (7) added, p. 387, § 6, effective January 15, 2000. **L. 2007:** (2)(c) repealed, p. 1922, § 3, effective January 1, 2008.

Editor's note: This section is similar to former §§ 10-4-317 and 10-4-406 as they existed prior to 1979.

10-4-419. Claims-made policy forms. (1) No insurer shall use or issue any policy, certificate, or contract of insurance or any portion thereof which provides coverage on a claims-made basis unless it has been certified by the insurer and the insurer has filed a certification with the commissioner that such policy endorsement or disclosure form or any portion thereof which provides coverage on a claims-made basis conforms to Colorado law pursuant to subsection (2) of this section and any rules and regulations promulgated pursuant to subsection (3) of this section.

(2) A claims-made policy shall not be delivered or issued for delivery to any person in this state unless:

(a) The insurer defines the nature of the risks or exposures to be insured on the claims-made policy;

(b) (I) The policy contains clear and adequate disclosure and alerts the insured to the fact that the policy is a claims-made policy and explains the unique features distinguishing it from an occurrence policy and relating to renewal, extended reporting periods, and coverage of occurrences with long periods of exposure. The commissioner shall promulgate regulations which establish proof of delivery and acceptance thereof by the policyholder and set forth the contents and format of the minimum disclosures required under this article.

(II) Such disclosures shall include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) A statement of the exceptions, reductions, and limitations contained in the policy;

(C) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums;

(D) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) The policy clearly defines the events and conditions which trigger coverage and defines when and how a claim is deemed to be made or is deemed made;

(d) The policy offers, at the insured's option, the purchase of an extended reporting period of at least one year for claims not filed during the policy period. The premium may not exceed two hundred percent of the expiring policy premium unless the adjusted premium is determined by the commissioner to be inadequate based upon section 10-4-403 and based upon an opinion of a qualified actuary submitted on behalf of the insurer.

(e) The policy requires insurers to furnish policyholders, upon their request and within thirty days thereafter, sufficient information about closed or paid claims, claims for which the company has established reserves, and claims for which the company has received notices of occurrences which could give rise to claims to allow the insured to determine how much of his aggregate coverage remains available under the policy;

(f) The insured approves and acknowledges, by signature on the written endorsement, any exclusionary endorsement which excludes coverage in a renewal period for claims from certain known occurrences, events, products, or locations;

(g) All persons engaged in the sale, consultation, or adjustment of the claims-made policy have been trained and certified pursuant to the standards and procedures set forth in regulations promulgated by the commissioner.

(3) (a) The commissioner may prohibit the use of a claims-made liability policy if the policy does not contain one or more of the following policy provisions:

(I) (Deleted by amendment, L. 2000, p. 466, § 5, effective August 2, 2000.)

(II) A policy provision that, in the event of cancellation or nonrenewal for any reason, the policy guarantees the insured the right of a sixty-day period to purchase coverage for an extended reporting period as provided in subparagraph (III) of this paragraph (a); or

(III) A policy provision that, at the insured's option, the insured may purchase coverage for an extended reporting period of at least the length of time of exposure under the applicable statute of limitation.

(IV) (Deleted by amendment, L. 2000, p. 466, § 5, effective August 2, 2000.)

(b) (Deleted by amendment, L. 2000, p. 466, § 5, effective August 2, 2000.)

(4) If a standardized claims-made policy form, proposed by a rating or advisory organization, has been filed with the commissioner and certified by the rating or advisory organization to be in compliance with statutory mandates, an insurer may utilize such a form.

(5) As used in this section, unless the context otherwise requires, "claims-made policy" means a policy of liability insurance that provides coverage for those claims that are made or reported to the insurance carrier, as is required in the policy, during the term of the policy or for such extended reporting term for which coverage has been purchased. A "claims-made policy" may include coverage for events occurring before the current policy term.

(6) This section shall not apply to any public entity self-insurance pool formed pursuant to section 24-10-115.5, C.R.S., or to any policy, certificate, or contract of insurance offered or issued by an insurer to such a pool.

(6.5) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

(7) All insurers providing insurance on a claims-made basis and who are authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, disclosure form, or any other evidence of coverage issued or delivered to any policyholder in Colorado. Such listing shall be submitted by July 15, 1993, and not later than July 1 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or disclosure form in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

(8) All insurers providing insurance on a claims-made basis and who are authorized by the commissioner to conduct business in Colorado shall also submit to the commissioner a list of any new policy form, endorsement, or disclosure form at least thirty-one days before using such policy form, endorsement, or disclosure form. Such listing shall also contain a certification by an officer of the organization that each new policy form, endorsement, or disclosure form proposed to be used complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

(9) The commissioner shall have the power to examine and investigate insurers authorized to conduct business in Colorado to determine whether claims-made policy forms, endorsements, or disclosure forms comply with the certification of the insurer and statutory mandates.

Source: L. 86: Entire section added, p. 581, § 6, effective July 1. **L. 87:** (2)(d) amended, p. 427, § 7, effective May 1. **L. 92:** (1), IP(2), IP(3)(a), and (4) amended and (7) to (9) added, p. 1558, § 59, effective May 20. **L. 96:** (2)(d) and (3)(a)(III) amended, p. 571, § 1, effective July 1. **L. 99:** (6.5) added, p. 388, § 7, effective January 15, 2000. **L. 2000:** (3) amended, p. 466, § 5, effective August 2.

Cross references: For the legislative declaration contained in the 2000 act amending subsection (3), see section 1 of chapter 135, Session Laws of Colorado 2000.

10-4-419.5. Workers' compensation form certification. An insurance carrier writing workers' compensation insurance in this state shall comply with section 8-44-102, C.R.S.

Source: L. 2014: Entire section added, (SB 14-137), ch. 78, p. 317, § 3, effective August 6.

10-4-420. Risk management procedures. Every insurer writing commercial property and casualty insurance in this state shall establish procedures to promote the use of loss control programs, safety programs, and other methods of risk management by its insureds to the extent feasible or practicable for the individual insured.

Source: L. 88: Entire section added, p. 402, § 1, effective April 29.

10-4-421. Notice of rate increases and decreases. (1) In the event that a rate filing for type II insurance for commercial liability includes a rate increase or decrease, the filing entity shall clearly identify in a cover letter accompanying the rate filing the specific portion of the rate

filing that represents such an increase or decrease and shall state clearly the percentage of any such proposed increase or decrease.

(2) This section shall not apply to insurers providing coverage for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 88: Entire section added, p. 404, § 1, effective May 17. **L. 99:** Entire section amended, p. 388, § 8, effective January 15, 2000.

PART 5

COLORADO INSURANCE GUARANTY ASSOCIATION ACT

10-4-501. Short title. This part 5 shall be known and may be cited as the "Colorado Insurance Guaranty Association Act".

Source: L. 71: p. 756, § 1. **C.R.S. 1963:** § 72-34-1.

10-4-502. Legislative declaration. The purposes of this part 5 are to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers.

Source: L. 71: p. 756, § 1. **C.R.S. 1963:** § 72-34-2.

10-4-503. Definitions. As used in this part 5, unless the context otherwise requires:

(1) "Account" means any one of the three accounts created by section 10-4-506.

(2) "Association" means the Colorado insurance guaranty association created under section 10-4-506.

(3) "Commissioner" means the commissioner of insurance of this state.

(4) (a) "Covered claim" means an unpaid claim, including one for unearned premiums:

(I) That arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this part 5 applies issued by an insurer if such insurer becomes an insolvent insurer after July 1, 1971; and

(II) With respect to which the claimant or insured is a resident of this state at the time of the insured event or the claim is a first-party claim for damage to property with a permanent location in this state.

(b) "Covered claim" does not include:

(I) Any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise; except that:

(A) A claim for any such amount asserted against a person insured under a policy issued by an insurer that has become insolvent and which claim would be a covered claim if it were not a claim by or for the benefit of a reinsurer, insurer, insurance pool, or underwriting association may be filed directly with the receiver or the insolvent insurer; and

(B) In no event may any such claim be asserted in any legal action against the insured of such insolvent insurer.

(II) A first-party claim by an insured whose net worth exceeds ten million dollars on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer. An insured's net worth on such date includes the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis.

(III) Any claim for incurred but not reported losses; except that nothing in this subparagraph (III) affects any covered claims or rights under this part 5.

(5) "Insolvent insurer" means an insurer licensed to transact insurance business in this state, either at the time the policy was issued or when the insured event occurred, and against whom an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile or of this state and which order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

(6) "Member insurer" means any person who writes any kind of insurance to which this part 5 applies under section 10-4-504, including the exchange of reciprocal or interinsurance contracts, and who is licensed to transact insurance business in this state.

(7) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this part 5 applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers and reinsurers.

(8) "Person" means any individual, corporation, partnership, association, or voluntary organization.

Source: L. 71: p. 756, § 1. **C.R.S. 1963:** § 72-34-5. **L. 77:** (4) amended, p. 513, § 1, effective May 27. **L. 79:** (5) amended, p. 385, § 1, effective May 31. **L. 99:** (4) amended, p. 86, § 1, effective August 4. **L. 2011:** (4) amended, (HB 11-1041), ch. 14, p. 38, § 1, effective August 10.

10-4-504. Scope. This part 5 shall apply to all kinds of direct insurance, except life, title, surety, sickness and accident, disability, credit, mortgage guaranty, financial guaranty, and ocean marine insurance.

Source: L. 71: p. 756, § 1. **C.R.S. 1963:** § 72-34-3. **L. 77:** Entire section amended, p. 513, § 4, effective May 27. **L. 89:** Entire section amended, p. 454, § 1, effective April 17. **L. 99:** Entire section amended, p. 87, § 2, effective August 4.

10-4-505. Construction. This part 5 shall be liberally construed to effect the purposes enumerated in section 10-4-502, which section shall constitute an aid and guide to interpretation.

Source: L. 71: p. 756, § 1. **C.R.S. 1963:** § 72-34-4.

10-4-506. Colorado insurance guaranty association. There is created a nonprofit unincorporated legal entity to be known as the Colorado insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority

to transact insurance business in this state. The association shall perform its functions under a plan of operation established and approved under section 10-4-509 and shall exercise its powers through a board of directors established under section 10-4-507. For purposes of administration and assessment, the association shall be divided into three separate accounts: Workers' compensation insurance account; automobile insurance account; and the account for all other insurance to which this part 5 applies.

Source: L. 71: p. 757, § 1. **C.R.S. 1963:** § 72-34-6. **L. 90:** Entire section amended, p. 559, § 17, effective July 1.

10-4-507. Board of directors. (1) The board of directors of the association shall consist of not less than five nor more than nine persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers, subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term in the same manner as initial appointments.

(2) In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for actual and necessary expenses incurred by them as members of the board of directors.

Source: L. 71: p. 757, § 1. **C.R.S. 1963:** § 72-34-7.

10-4-508. Powers and duties of association. (1) The association shall:

(a) (I) Be obligated to the extent of the covered claims existing prior to a determination of insolvency and arising within thirty days after the determination of insolvency, or before the policy expiration date, if less than thirty days after such determination, or before the insured replaces the policy or on request effects cancellation, if the insured does so within thirty days after such determination, but such obligation includes only that amount of each covered claim that is less than fifty thousand dollars; except that:

(A) For an order of liquidation with a finding of insolvency by a court of competent jurisdiction entered between July 1, 1988, and August 10, 2011, such obligation includes only that amount of each covered claim that is less than one hundred thousand dollars;

(B) For an order of liquidation with a finding of insolvency by a court of competent jurisdiction entered on or after August 10, 2011, such obligation includes only that amount of each covered claim that is less than three hundred thousand dollars; and

(C) Notwithstanding sub-subparagraph (A) or (B) of this subparagraph (I), the association shall pay the full amount of any covered claim arising out of workers' compensation policies.

(II) In no event is the association obligated to a policyholder or claimant in an amount in excess of the face amount of the policy from which the claim arises.

(III) Notwithstanding any other provision of this part 5, a covered claim does not include any claim filed with the guaranty fund after the earlier of:

(A) Twenty-four months after the date of the order of liquidation; or

(B) The final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

(b) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent;

(c) Allocate claims paid and expenses incurred among the three accounts separately and assess member insurers amounts separately for each account necessary to pay: The obligations of the association under paragraph (a) of this subsection (1) subsequent to an insolvency; the expenses of handling covered claims subsequent to an insolvency; the cost of examinations under section 10-4-513; and other expenses authorized by this part 5. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than two percent of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; but during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital and surplus below required minimums. Such payment shall be refunded to those companies receiving larger assessments by virtue of such deferment or, in the discretion of any such company, credited against future assessments. Each member insurer may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made.

(d) Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation, and deny all other claims, and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases, and judgments may be properly contested;

(e) Notify such persons as the commissioner directs under section 10-4-510 (2)(a);

(f) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer.

(g) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this part 5.

(2) The association may:

(a) Employ or retain such persons as are necessary to handle claims and perform other duties of the association;

(b) Borrow funds necessary to effect the purposes of this part 5 in accord with the plan of operation;

(c) Sue or be sued, and such power to sue includes the power and right to intervene as a party before any court in this state that has jurisdiction over an insolvent insurer, as defined in section 10-4-503 (5);

(d) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this part 5;

(e) Perform such other acts as are necessary or proper to effectuate the purposes of this part 5;

(f) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.

Source: L. 71: p. 758, § 1. **C.R.S. 1963:** § 72-34-8. **L. 77:** (1)(a) amended, p. 514, § 3, effective May 27. **L. 88:** (1)(a) amended, p. 407, § 1, effective July 1. **L. 90:** (1)(a) amended, p. 559, § 18, effective July 1. **L. 99:** (2)(c) amended, p. 87, § 4, effective August 4. **L. 2002:** (1)(c) amended, p. 75, § 1, effective March 22. **L. 2011:** (1)(a) amended, (HB 11-1041), ch. 14, p. 39, § 2, effective August 10.

10-4-508.5. Aggregate liability of association. (1) (a) Notwithstanding any other provisions of this part 5, except in the case of a claim for benefits under workers' compensation coverage, any obligation of the association to any and all persons shall cease when ten million dollars shall have been paid in the aggregate by the association and any one or more associations similar to the association of any other state or states or any property/casualty insurance security fund that obtains contributions from insurers on a pre-insolvency basis, to or on behalf of any insured and its affiliates on covered claims or allowed claims arising under the policy or policies of any one insolvent insurer.

(b) For purposes of this section, the term "affiliate" shall mean a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(2) If the association determines that there may be more than one claimant having a covered claim or allowed claim against the association or any associations similar to the association or any property/casualty insurance security fund in other states, under the policy or policies of any one insolvent insurer, the association may establish a plan to allocate amounts payable by the association in such manner as the association in its discretion deems equitable.

Source: L. 99: Entire section added, p. 87, § 3, effective August 4.

10-4-509. Plan of operation. (1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the commissioner.

(2) If the association fails to submit a suitable plan of operation within ninety days following July 1, 1971, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this part 5. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(3) All member insurers shall comply with the plan of operation.

(4) The plan of operation shall:

(a) Establish the procedures whereby all the powers and duties of the association under section 10-4-508 will be performed;

(b) Establish procedures for handling assets of the association;

(c) Establish the amount and method of reimbursing members of the board of directors under section 10-4-507;

(d) Establish procedures by which claims may be filed with the association and provide acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent, and a list of such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

(e) Establish regular places and times for meetings of the board of directors;

(f) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(g) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty days after the action or decision;

(h) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner;

(i) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(5) The plan of operation may provide that any or all powers and duties of the association, except those under section 10-4-508 (1)(c) and (2)(c), are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection (5) shall take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this part 5.

Source: L. 71: p. 759, § 1. **C.R.S. 1963:** § 72-34-9.

10-4-510. Duties and powers of commissioner. (1) The commissioner shall:

(a) Notify the association of the existence of an insolvent insurer not later than three days after he receives notice of the determination of the insolvency;

(b) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(2) The commissioner may:

(a) Require that the association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this part 5. Such notification shall be by first-class mail at their last-known addresses, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(b) Require each agent of the insolvent insurer to give prompt written notice to each insured of the insolvent insurer for whom he was agent of record by sending such notice by first-class mail to the insured's last-known address;

(c) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. Such fine shall not exceed five percent of the unpaid assessment per month; except that no fine shall be less than one hundred dollars per month.

(d) Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

(3) Any final action or order of the commissioner under this part 5 shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 71: p. 760, § 1. **C.R.S. 1963:** § 72-34-10. **L. 92:** (3) amended, p. 1559, § 60, effective May 20.

10-4-511. Effect of paid claims. (1) Any person recovering under this part 5 from the association shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this part 5 shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out.

(2) The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this part 5 against the assets of the insolvent insurer. The expenses of the association or a similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(3) The association shall periodically file with the receiver or liquidator of an insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association, which shall preserve the rights of the association against the assets of the insolvent insurer.

(4) (a) The association shall have the right to recover from the following persons the amount of any covered claim paid on behalf of such person pursuant to this part 5:

(I) Any insured whose net worth on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds twenty-five million dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under this part 5. An insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis; and

(II) Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this part 5.

(b) The association and any similar organization in another state shall be recognized as claimants in the liquidation of an insolvent insurer for any amounts paid by them on covered claims obligations as determined under this part 5 or similar laws in other states and shall receive dividends and any other distributions at the priority set forth in part 5 of article 3 of this title. The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by determinations of covered claim eligibility under this part 5 and by settlements of claims made by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this part 5 against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

Source: L. 71: p. 761, § 1. **C.R.S. 1963:** § 72-34-11. **L. 77:** (2) amended, p. 514, § 4, effective May 27. **L. 99:** (4) added, p. 87, § 5, effective August 4.

10-4-512. Nonduplication of recovery. (1) Any person having a claim against an insurer under any provision in any insurance policy that is also a covered claim shall exhaust first the person's right under such policy. Any amount payable on a covered claim under this part 5 is reduced by the amount recoverable under such insurance policy.

(2) Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured; except that, if it is a first-party claim for damage to property with a permanent location, recovery shall be sought from the association of the location of the property, and, if it is a workers' compensation claim, recovery shall be sought from the association of the residence of the claimant. A claimant or first-party insured who has received a recovery from any other guaranty association or its equivalent in an amount equal to or greater than the recovery allowed under this part 5 shall not be eligible to receive any recovery from the Colorado insurance guaranty association. In addition, any recovery under this part 5 shall be reduced by the amount of the recovery from any other insurance guaranty association or its equivalent.

Source: L. 71: p. 761, § 1. **C.R.S. 1963:** § 72-34-12. **L. 89:** (2) amended, p. 454, § 2, effective April 17. **L. 90:** (2) amended, p. 559, § 19, effective July 1. **L. 99:** (2) amended, p. 88, § 6, effective August 4. **L. 2011:** (1) amended, (HB 11-1041), ch. 14, p. 40, § 3, effective August 10.

10-4-513. Prevention of insolvencies. (1) To aid in the detection and prevention of insurer insolvencies, it is the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating that any member insurer may be insolvent or is in a financial condition hazardous to the policyholders or the public.

(2) To aid in the detection and prevention of insurer insolvencies, it is the duty of the commissioner:

(a) To notify the commissioners of all other states and territories of the United States and the District of Columbia by mail within thirty days of any of the following actions taken by him against a member insurer:

(I) Revocation of license;

(II) Suspension of license;

(III) Any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors;

(b) To report to the board of directors when he has taken any of the actions set forth in paragraph (a) of this subsection (2) or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(c) To report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of any member company that such company may be insolvent or in a financial condition hazardous to the policyholders or the public;

(d) To furnish to the board of directors the early warning tests developed by the national association of insurance commissioners. The board of directors may use the information contained in such tests in carrying out its duties and responsibilities pursuant to this section. Such report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner of another lawful authority.

(3) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member companies and companies seeking admission to transact insurance business in this state.

(4) The board of directors, upon majority vote, may make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do business in this state. Such reports and recommendations shall not be considered public documents.

(5) It is the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating that any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.

(6) The board of directors, upon majority vote, may request that the commissioner order an examination of any member insurer which the board in good faith believes to be in a financial condition hazardous to the policyholders or the public. Within thirty days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by such persons as the commissioner designates. The cost of such examination shall be paid by the association, and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (1) of this section. The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.

(7) The board of directors, upon majority vote, may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(8) The board of directors, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, shall prepare a report to the commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board of directors shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular insurer and may adopt by reference any report prepared by such other associations.

Source: L. 71: p. 762, § 1. **C.R.S. 1963:** § 72-34-13. **L. 77:** Entire section R&RE, p. 514, § 5, effective May 27.

10-4-514. Examination of association. The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

Source: L. 71: p. 762, § 1. **C.R.S. 1963:** § 72-34-14.

10-4-515. Tax exemption. The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real or personal property.

Source: L. 71: p. 762, § 1. **C.R.S. 1963:** § 72-34-15.

10-4-516. Recognition of assessments in rates. The rates and premiums charged for insurance policies to which this part 5 applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer, less any amounts returned to the member insurer by the association, and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

Source: L. 71: p. 762, § 1. **C.R.S. 1963:** § 72-34-16.

10-4-517. Immunity. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, the association or its agents or employees, the board of directors, or the commissioner or his representatives for any action taken by them in the performance of their powers and duties under this part 5.

Source: L. 71: p. 763, § 1. **C.R.S. 1963:** § 72-34-17.

10-4-518. Stay of proceedings. All proceedings to which an insolvent insurer is a party in any court in this state shall be stayed for sixty days after the date the insolvency is determined to permit proper defense by the association of all pending causes of action.

Source: L. 71: p. 763, § 1. **C.R.S. 1963:** § 72-34-18.

Cross references: For stay of proceedings to permit proper defense by the Colorado insurance guaranty association, see § 10-4-508 (1)(d) regarding the exercise of powers and duties relevant thereto.

10-4-519. Termination - distribution of funds. (1) The commissioner shall by order terminate the operation of the association as to any kind of insurance covered by this part 5 with respect to which he has found, after hearing, that there is in effect a statutory or voluntary plan which:

(a) Is a permanent plan which is adequately funded or for which adequate funding is provided; and

(b) Extends, or will extend, to the Colorado policyholders and residents protection and benefits with respect to insolvent insurers not substantially less favorable and effective to such policyholders and residents than the protection and benefits provided with respect to such kinds of insurance under this part 5.

(2) The commissioner shall by the same order authorize discontinuance of future payments by insurers to the association with respect to the same kinds of insurance; but the assessments and payments shall continue, as necessary, to liquidate covered claims of insurers adjudged insolvent prior to said order and the related expenses not covered by such other plan.

(3) In the event the operation of the association is so terminated as to all kinds of insurance otherwise within its scope, the association as soon as possible thereafter shall distribute the balance of moneys and assets remaining after discharge of the functions of the association with respect to prior insurer insolvencies not covered by such other plan, together with related expenses, to the insurers which are then writing in this state policies of the kinds of insurance covered by this part 5 and which have made payments to the association pro rata upon the basis of the aggregate of such payments made by the respective insurers during the period of five years next preceding the date of such order. Upon completion of such distribution with respect to all of the kinds of insurance covered by this part 5, this part 5 shall be deemed to be repealed.

Source: L. 71: p. 763, § 1. **C.R.S. 1963:** § 72-34-19.

10-4-520. Advertising. No person, including an insurer, agent, or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in any newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster or over any radio station or television station or in any other way any advertisement, announcement, or statement which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by this part 5, but this section shall not apply to the Colorado insurance guaranty association or to any other entity which does not sell or solicit insurance.

Source: L. 77: Entire section added, p. 516, § 6, effective May 27.

PART 6

Cross references: For abuse of property insurance, see § 18-13-119.5.

10-4-601. Definitions. As used in this part 6, unless the context otherwise requires:

(1) Repealed.

(2) "Complying policy" means a policy of insurance that provides the coverages and is subject to the terms and conditions required by this part 6, and is certified by the insurer and the insurer has filed a certification with the commissioner that such policy, contract, or endorsement conforms to Colorado law and any rules promulgated by the commissioner.

(3) "Converter" means a person other than a named insured or resident relative who operates or uses a motor vehicle in a manner that a reasonable person would determine was unauthorized or beyond the scope of permission given by a named insured or resident relative. In determining whether a person is a converter, the following factors should be considered:

(a) The duration of the person's control over the motor vehicle;

(b) The circumstances surrounding the conduct of the person operating or using the motor vehicle; and

(c) The person's good faith.

(4) "Described motor vehicle" means the motor vehicle described in the complying policy.

(5) "Insured" means the named insured, relatives of the named insured who reside in the same household as the named insured, and any person using the described motor vehicle with the permission of the named insured.

(5.5) "Licensed health-care provider" means a person, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a hospital, health-care facility, or dispensary or to practice and practicing medicine, osteopathy, chiropractic, nursing, physical therapy, podiatry, dentistry, pharmacy, acupuncture, or optometry in this state, or an officer, employee, or agent of the person, corporation, facility, or institution working under the supervision of the person, corporation, facility, or institution in providing health-care services.

(6) **[*Editor's note: This version of subsection (6) is effective until July 1, 2027.*]** "Motor vehicle" means a "motor vehicle" and a "low-power scooter", as both terms are defined in section 42-1-102, C.R.S.; except that "motor vehicle" does not include a toy vehicle, snowmobile, off-highway vehicle, or vehicle designed primarily for use on rails.

(6) **[*Editor's note: This version of subsection (6) is effective July 1, 2027. For the applicability of this subsection (6) on or after January 1, 2028, see the editor's note following this section.*]** "Motor vehicle" means a "motor vehicle", a "kei vehicle", and a "low-power scooter", as each of these terms is defined in section 42-1-102; except that "motor vehicle" does not include a toy vehicle, snowmobile, off-highway vehicle, or vehicle designed primarily for use on rails.

(7) "Nonpayment of premium" means failure of the named insured to discharge when due any obligations in connection with the payment of premiums on the policy, or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

(8) "Owner" means a person who holds the legal title to a vehicle; except that, if the vehicle is the subject of an agreement for the conditional sale or lease thereof with the right of purchase upon performance of the conditions stated in the agreement and with an immediate right of possession vested in the conditional vendee or lessee, or if a mortgagor of the vehicle is entitled to possession, then such conditional vendee or lessee or mortgagor shall be deemed the owner for the purpose of this part 6.

(9) "Person" means every natural person, firm, partnership, association, or corporation.

(10) "Policy" means an automobile insurance policy providing coverage for all or any of the following coverages: Collision, comprehensive, bodily injury liability, property damage liability, medical payments, and uninsured motorist coverage, or a combination automobile policy providing bodily injury liability, property damage liability, medical payments, uninsured motorist, and physical damage coverage, delivered or issued for delivery in this state, insuring a single individual, or husband and wife, or family members residing in the same household, as named insured, and under which the insured vehicles therein designated are of the following types only:

(a) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers nor rented to others pursuant to the terms of a motor vehicle rental agreement; or

(b) Any other four-wheel motor vehicle with a load capacity of fifteen hundred pounds or less that is not used in the occupation, profession, or business of the insured.

(11) "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer or by an admitted company within the same insurance group, or the issuance and delivery of a certificate or notice extending the term of the policy beyond its policy period or term; but any policy with a policy period or term of less than six months shall, for the purpose of this part 6, be considered as if written for a policy period or term of six months; and any policy written for a term longer than one year, or any policy with no fixed expiration date, shall, for the purpose of this part 6, be considered as if written for successive policy periods or terms of one year, and such policy may be terminated at the expiration of any annual period upon giving twenty days' notice of cancellation prior to such anniversary date, and such cancellation shall not be subject to any other provisions of this part 6.

(12) Repealed.

(13) "Resident relative" means a person who, at the time of the accident, is related by blood, marriage, or adoption to the named insured or resident spouse and who resides in the named insured's household, even if temporarily living elsewhere, and any ward or foster child who usually resides with the named insured, even if temporarily living elsewhere.

(14) "Stacking" has the same meaning set forth in section 10-4-402 (3.5).

Source: L. 69: p. 549, § 1. **C.R.S. 1963:** § 72-30-1. **L. 92:** (4) added, p. 1759, § 3, effective June 5. **L. 95:** (2)(a) amended, p. 142, § 2, effective April 7. **L. 2003:** Entire section amended, p. 1558, § 1, effective July 1; (1) amended and (1.5) and (3.5) added, p. 2554, § 1, effective July 1. **L. 2004:** (6) amended, p. 11, § 2, effective February 20. **L. 2007:** (1) and (12) repealed, p. 974, § 3, effective May 18. **L. 2009:** (6) amended, (HB 09-1026), ch. 281, p. 1253, § 1, effective July 1, 2010. **L. 2010:** (5.5) added, (HB 10-1220), ch. 197, p. 855, § 18, effective

July 1. **L. 2016:** (11) amended, (HB 16-1025), ch. 16, p. 36, § 1, effective August 10. **L. 2025:** (6) amended, (HB 25-1281), ch. 176, p. 735, § 1, effective July 1, 2027.

Editor's note: (1) Amendments to this section by House Bill 03-1253 and House Bill 03-1188 were harmonized, resulting in the renumbering of provisions of this section.

(2) Section 13(2) of chapter 176 (HB 25-1281), Session Laws of Colorado 2025, provides that the act changing this section applies to applications submitted or offenses committed on or after January 1, 2028.

10-4-601.5. Administrative authority. The commissioner shall administer and enforce the provisions of this part 6, may make rules necessary for the administration of this part 6 in accordance with article 4 of title 24, and may enforce the provisions of part 12 of article 1 of title 6 that apply to an insurer or a policy.

Source: L. 2003: Entire section added, p. 1560, § 3, effective July 1. **L. 2019:** Entire section amended, (SB 19-090), ch. 391, p. 3500, § 2, effective January 1, 2020.

10-4-602. Basis for cancellation. (1) A notice of cancellation of a policy shall be valid only if it is based on one or more of the following reasons:

(a) Nonpayment of premium; or

(b) The driver's license or motor vehicle registration of either the named insured or any operator either residing in the insured's household or who customarily operates an automobile insured under the policy has been under suspension or revocation during the policy period or, if the policy is a renewal, during its policy period or the one hundred eighty days immediately preceding its effective date; or

(c) An applicant knowingly made a false statement on the application for insurance; or

(d) An insured knowingly and willfully made a false material statement on a claim submitted under the policy.

(2) This section shall not apply to any policy or coverage which has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer, unless it is a renewal policy.

(3) This section shall not apply to nonrenewal of a policy.

Source: L. 69: p. 550, § 2. **C.R.S. 1963:** § 72-30-2. **L. 94:** (1)(c) amended and (1)(d) added, p. 328, § 1, effective July 1.

10-4-603. Notice. (1) No notice of cancellation of a policy to which section 10-4-602 applies shall be valid unless mailed or delivered by the insurer to the named insured at least thirty days prior to the effective date of cancellation; but, where cancellation is for nonpayment of premium, at least ten days' notice of cancellation accompanied by the reason therefor shall be given or, alternatively, a notice advising that the policy will be canceled if timely payment of premium is not made may be given at least ten days but not more than thirty days prior to the premium due date. Unless the reason accompanies or is included in the notice of cancellation, the notice of cancellation shall state or be accompanied by a statement that, upon written request of the named insured, mailed or delivered to the insurer not less than fifteen days prior to the

effective date of cancellation, the insurer will specify the reason for such cancellation. As used in this section, "premium due date" means the date that a premium that has been previously paid is fully earned.

(2) Where the reason for cancellation does not accompany or is not included in the notice of cancellation, the insurer shall, upon written request of the named insured, mailed or delivered to the insurer not less than fifteen days prior to the effective date of cancellation, specify in writing the reason for such cancellation. Such reason shall be mailed or delivered to the named insured within five days after receipt of such request.

(3) This section shall not apply to nonrenewal of a policy.

Source: L. 69: p. 550, § 3. **C.R.S. 1963:** § 72-30-3. **L. 96:** (1) amended, p. 363, § 1, effective April 17.

10-4-604. Nonrenewal. (1) No insurer shall refuse to renew a policy unless such insurer or its agent mails or delivers to the named insured, at the address shown in the policy, at least thirty days' advance notice of its intention not to renew. This section shall not apply:

(a) If the insurer has manifested its willingness to renew;

(b) In case of nonpayment of premium;

(c) If the insured fails to pay any advance premium required by the insurer for renewal.

(2) Notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies.

(3) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

(4) In the event an insurer refuses to renew, the insured may, by written request, demand a written notification of the reason for nonrenewal. Such notification shall be given the insured within twenty days after receipt of such request.

Source: L. 69: p. 550, § 4. **C.R.S. 1963:** § 72-30-4. **L. 96:** (1) amended, p. 363, § 2, effective April 17.

10-4-604.5. Issuance or renewal of insurance policies - proof of insurance provided by certificate, card, or other media. (1) In addition to any other requirement, if an insurer issues or renews a policy of insurance, the insurer shall provide the insured a proof of insurance certificate or insurance identification card to accompany the insured's registration application or renewal card or provide proof of insurance in such other media as is authorized by the department under section 42-3-105 (1)(d), C.R.S. The insurance identification card may be provided in either paper or electronic format. Acceptable electronic formats include display of electronic images on a cellular phone or any other type of portable electronic device.

(2) (Deleted by amendment, L. 2003, p. 1560, § 2, effective July 1, 2003.)

Source: L. 98: Entire section added, p. 787, § 6, effective July 1, 1999. **L. 2000:** (1) amended, p. 511, § 3, effective May 12. **L. 2001:** (2) amended, p. 524, § 9, effective May 22. **L. 2003:** Entire section amended, p. 1560, § 2, effective July 1. **L. 2006:** (1) amended, p. 1491, §

13, effective June 1. **L. 2013:** (1) amended, (HB 13-1159), ch. 101, p. 322, § 2, effective August 7.

10-4-605. Proof of notice. Proof of mailing notice of cancellation, or of intention not to renew or of reasons for cancellation, to the named insured at the address shown in the policy shall be sufficient proof of notice.

Source: L. 69: p. 551, § 5. **C.R.S. 1963:** § 72-30-5.

10-4-606. Further notice. When automobile bodily injury and property damage liability coverage is canceled, other than for nonpayment of premium, or in the event of failure to renew automobile bodily injury and property damage liability coverage to which section 10-4-604 applies, the insurer shall notify the named insured of his possible eligibility for automobile liability insurance through an assigned risk plan established pursuant to section 10-4-412 and shall notify the insured as to where he may obtain information concerning such plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew.

Source: L. 69: p. 551, § 6. **C.R.S. 1963:** § 72-30-6. **L. 79:** Entire section amended, p. 376, § 9, effective July 1.

10-4-607. Immunity. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the commissioner or against any insurer, its authorized representative, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal, or for any statement made by any of them in any written notice of cancellation or notification of reason for nonrenewal, or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal, or the providing of information with respect thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

Source: L. 69: p. 551, § 7. **C.R.S. 1963:** § 72-30-7.

10-4-608. Exemptions. (1) This part 6 does not apply to any policy:

(a) Issued under an assigned risk plan established under section 10-4-412;

(b) Repealed.

(c) Except as authorized by section 10-4-624, arising out of a motor vehicle rental agreement or any self-insurance thereof;

(d) Covering a garage, automobile sales agency, repair shop, service station, or public parking place operation hazard; or

(e) Issued principally to cover personal or premises liability of an insured even though such insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance, or use of a motor vehicle on the premises of such insured, or on the ways immediately adjoining such premises.

Source: L. 69: p. 551, § 8. **C.R.S. 1963:** § 72-30-8. **L. 79:** Entire section amended, p. 376, § 10, effective July 1. **L. 95:** Entire section amended, p. 143, § 3, effective April 7. **L. 2003:**

(1)(c) amended, p. 2433, § 1, effective June 5. **L. 2017:** IP(1) amended and (1)(b) repealed, (SB 17-249), ch. 283, p. 1548, § 16, effective June 1.

10-4-609. Insurance protection against uninsured motorists - applicability. (1) (a) (I) Except as described in subsection (1)(a)(II) of this section, an automobile liability or motor vehicle liability policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle, which policy is delivered or issued for delivery in this state with respect to any motor vehicle licensed for highway use in this state, must provide coverage or supplemental coverage, in limits for bodily injury or death set forth in section 42-7-103 (2), under provisions approved by the commissioner, for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, or disease, including death, resulting from a motor vehicle accident.

(II) Subsection (1)(a)(I) of this section does not apply if the named insured rejects the coverage described in subsection (1)(a)(I) of this section in writing; except that, if the named insured is a transportation network company, as defined in section 40-10.1-602 (3), securing coverage for a transportation network company driver, as defined in section 40-10.1-602 (4), to protect against damages caused by uninsured motorists, as described in section 40-10.1-604 (2.5), the named insured may not reject the coverage for periods when the transportation network company driver is engaged in a prearranged ride, as defined in section 40-10.1-602 (2).

(b) This subsection (1) shall not apply to motor vehicle rental agreements or motor vehicle rental companies.

(c) The coverage described in paragraph (a) of this subsection (1) shall be in addition to any legal liability coverage and shall cover the difference, if any, between the amount of the limits of any legal liability coverage and the amount of the damages sustained, excluding exemplary damages, up to the maximum amount of the coverage obtained pursuant to this section. A single policy or endorsement for uninsured or underinsured motor vehicle coverage issued for a single premium covering multiple vehicles may be limited to applying once per accident. The amount of the coverage available pursuant to this section shall not be reduced by a setoff from any other coverage, including, but not limited to, legal liability insurance, medical payments coverage, health insurance, or other uninsured or underinsured motor vehicle insurance.

(2) Before the policy is issued or renewed, the insurer shall offer the named insured the right to obtain uninsured motorist coverage in an amount equal to the insured's bodily injury liability limits, but in no event shall the insurer be required to offer limits higher than the insured's bodily injury liability limits.

(3) Notwithstanding the provisions of subsection (2) of this section, after selection of limits by the insured or the exercise of the option not to purchase the coverages described in this section, no insurer nor any affiliated insurer shall be required to notify any policyholder in any renewal or replacement policy, as to the availability of such coverage or optional limits. However, the insured may, subject to the limitations expressed in this section, make a written request for additional coverage or coverage more extensive than that provided on a prior policy.

(4) Uninsured motorist coverage shall include coverage for damage for bodily injury or death that an insured is legally entitled to collect from the owner or driver of an underinsured

motor vehicle. An underinsured motor vehicle is a land motor vehicle, the ownership, maintenance, or use of which is insured or bonded for bodily injury or death at the time of the accident.

(5) (Deleted by amendment, L. 2007, p. 1921, § 2, effective January 1, 2008.)

(6) An alleged tortfeasor shall be deemed to be uninsured solely for the purpose of allowing the insured party to receive payment under uninsured motorist coverage, regardless of whether the alleged tortfeasor was actually insured, if:

(a) The alleged tortfeasor cannot be located for service of process after a reasonable attempt to serve the alleged tortfeasor; and

(b) (I) Service of process on the insurance carrier as authorized by section 42-7-414 (3), C.R.S., is determined by a court to be insufficient or ineffective after reasonable effort has failed; or

(II) (A) The report of a law enforcement agency investigating the motor vehicle accident fails to disclose the insurance company covering the alleged tortfeasor's motor vehicle; and

(B) The alleged tortfeasor's insurance coverage when the incident occurred is not actually known by the person attempting to serve process.

(7) Nothing in subsection (6) of this section voids the alleged tortfeasor's policy if the alleged tortfeasor was actually insured.

Source: L. 79: Entire section added, p. 377, § 11, effective July 1. **L. 83:** Entire section R&RE, p. 454, § 1, effective November 5. **L. 92:** (2) amended, p. 1759, § 4, effective June 5. **L. 95:** (1) amended, p. 143, § 4, effective April 7. **L. 2007:** (1)(c) added and (2), (4), and (5) amended, p. 1921, §§ 1, 2, effective January 1, 2008. **L. 2010:** (6) and (7) added, (HB 10-1164), ch. 196, p. 845, § 1, effective January 1, 2011. **L. 2022:** (1)(a) amended, (HB 22-1089), ch. 169, p. 1037, § 2, effective August 10.

10-4-610. Property damage protection against uninsured motorists. (1) Every policy providing insurance for bodily injury caused by uninsured motorists that is delivered or issued for delivery in this state, which policy does not also provide insurance for collision damage, shall provide, at the request of the insured, coverage for the protection of persons insured thereunder who are legally entitled to recover damages from the owner or operator of an uninsured motor vehicle because of property damage to the motor vehicle described in the policy arising out of the operation, maintenance, or use of the uninsured motor vehicle. The coverage provided under this section shall cover the actual cash value of the vehicle or the cost of repair or replacement, whichever is less. Any coverage offered pursuant to this section on a vehicle may be subject to a deductible, at the option of the insurer, as with other property damage coverage. The coverage provided under this section shall not provide protection for:

(a) Damage if there is not actual physical contact between the covered motor vehicle and another motor vehicle;

(b) Damages which are paid or payable under any other property insurance;

(c) Loss of use of a motor vehicle.

(2) Repealed.

Source: L. 88: Entire section added, p. 409, § 1, effective January 1, 1989. **L. 89:** IP(1) and (1)(a) amended and (1)(c) and (2) added, p. 456, § 1, effective July 1. **L. 2006:** (2) repealed, p. 37, § 2, effective January 1, 2007.

10-4-611. Elimination of discounts - damage by uninsured motorist. No rating discounts applied to any policy of motor vehicle insurance issued in this state shall be reduced or eliminated as the result of a collision with an uninsured motor vehicle where the operator of the insured motor vehicle is not at fault.

Source: L. 88: Entire section added, p. 409, § 1, effective January 1, 1989.

10-4-612. Study concerning implementation of proof of insurance. (Repealed)

Source: L. 92: Entire section added, p. 1502, § 1, effective June 3. **L. 96:** Entire section repealed, p. 1229, § 50, effective August 7.

10-4-613. Glass repair and replacement. (1) No insurance company, domestic or foreign, or any agent or employee of such a company, shall require or permit that automobile glass repair or replacement work must be performed by a particular facility, individual, or business establishment as a condition of payment of a claim. However, an insurance company may provide that payments for such work shall be limited to a fair competitive price. No insurance company that issues, delivers, or renews such a policy shall fail to pay for the repair or replacement of automobile glass by an insured's chosen vendor, nor shall any such insurance company engage in any act or practice of intimidation, coercion, or threat for or against any insured person or entity to use a particular vendor or location for such glass repair or replacement work. No insurance company shall agree to refund or rebate any applicable deductible or portion thereof as an incentive or inducement to any insured to use a particular vendor or location for glass repair or replacement work. The provisions of this section shall apply to all policies of insurance delivered, issued for delivery, or renewed in this state that cover motor vehicles.

(2) Notwithstanding the provisions of subsection (1) of this section, an insurance company may agree to pay the full cost of glass repair, notwithstanding any applicable deductible.

Source: L. 92: Entire section added, p. 1791, § 1, effective April 16.

Editor's note: This section was originally numbered as § 10-4-612 in House Bill 92-1275 but was renumbered on revision for ease of location.

10-4-614. Inflatable restraint systems - replacement - verification of claims - definition. (1) If an insured receives payment for a policy claim for an inflatable restraint system that has inflated and deployed or been stolen, the insured shall replace such inflatable restraint system in the motor vehicle. Upon receiving such a policy claim, the insurer is authorized to inspect the vehicle for which the claim is being filed to verify that the inflatable restraint system did inflate and deploy or was stolen.

(2) For the purposes of this section, "inflatable restraint system" has the same meaning as is set forth in 49 CFR 571.208 S4.1.5.1 (b).

Source: L. 97: Entire section added, p. 796, § 1, effective August 6. **L. 2020:** (2) amended, (HB 20-1402), ch. 216, p. 1042, § 12, effective June 30.

10-4-615. Motorist insurance identification database program - reporting required - fine. (1) (a) Each insurer that issues a policy pursuant to this part 6 shall provide to the department of revenue a record of each policy issued during the immediately preceding period. Such record shall comply with the requirements of subsections (2) and (3) of this section. This subsection (1) shall not be construed to prohibit more frequent reporting. Such policy information shall be provided to the department as follows:

(I) and (II) (Deleted by amendment, L. 2006, p. 1014, § 10, effective July 1, 2006.)

(III) Each insurer with any policies in place for the preceding six months shall provide such policy information every week for the immediately preceding week. Such information shall be reported no later than seven working days after the last date of the week reported on.

(b) Each insurer shall provide policy information on all existing policies issued by such insurer to the department at least every six months. The department and the working group created in section 42-7-604 (4)(b), C.R.S., shall determine if any new means of transmittal of such information may be utilized. Each insurer shall provide information regarding changes to existing policies to the department at the time of receipt of such information.

(2) The record described in subsection (1) of this section shall include:

(a) The name, date of birth, driver's license number, and address of each named insured owner or operator;

(b) The make, year, and vehicle identification number of each insured motor vehicle; and

(c) The policy number, effective date, and expiration date of each policy.

(3) Each insurer shall provide the required information in a form or manner acceptable to the designated agent.

(4) (a) The division of insurance shall assess a fine of not more than two hundred fifty dollars against an insurer for each day such insurer fails to report timely and accurate information in accordance with this section or with rules promulgated pursuant to section 42-7-604 (8), C.R.S. Any administrative costs incurred by the division of insurance shall be paid from the fines assessed pursuant to this paragraph (a).

(b) The commissioner shall excuse the fine if an insurer provides proof that its failure to comply was inadvertent, accidental, or the result of excusable neglect.

(5) (Deleted by amendment, L. 2006, p. 1014, § 10, effective July 1, 2006.)

(6) Repealed.

Source: L. 97: Entire section added, p. 1444, § 1, effective July 1. **L. 2000:** (4)(a) amended, p. 1635, § 8, effective June 1. **L. 2001:** (4)(a) and (6) amended, p. 522, § 3, effective May 22. **L. 2003:** (1), (4)(a), and (6) amended, p. 2645, § 1, effective July 1. **L. 2004:** IP(1)(a) and (1)(a)(III) amended, p. 796, § 8, effective May 21. **L. 2006:** (1) and (5) amended and (6) repealed, pp. 1014, 1010, §§ 10, 2, effective July 1.

10-4-616. Disclosure of credit reports. (1) (a) Insurers using new or updated credit information in insurance underwriting or rating shall notify applicants or policyholders that their credit information will be used for underwriting or rating.

(b) When an insurer uses a producer for such disclosure, the insurer shall provide the producer with the form of such notice and use a reasonable means to verify that such notice is given. The disclosure notice form shall be developed by the insurer.

(c) Upon request by an applicant or policyholder, an insurer or producer shall provide an explanation of the significant characteristics of the credit information that impact the policyholder's insurance score. This information may be included in the disclosure notice form.

(2) If the use of credit information results in an adverse action to a consumer, the insurer shall comply with the notice requirements of the federal "Fair Credit Reporting Act", 15 U.S.C. sec. 1681 et seq. Such notice shall include, but is not limited to:

(a) The identity, telephone number, and address of any consumer reporting agency from whom a credit report was obtained;

(b) Notice of the consumer's right to receive a free credit report from the consumer reporting agency for a period of sixty days if such report resulted in an adverse action; and

(c) Notice of the consumer's right to lodge a dispute with the consumer reporting agency and have any erroneous information corrected in accordance with the federal "Fair Credit Reporting Act", 15 U.S.C. sec. 1681 et seq.

(3) For the purposes of this section, "adverse action" means a denial, cancellation, or nonrenewal of, an increase in any charge for, a placement into a higher tier, or a reduction or unfavorable change in the terms of coverage or amount of insurance in connection with underwriting of existing insurance or an application for insurance.

Source: L. 2003: Entire section added, p. 839, § 1, effective July 1, 2004.

10-4-617. Insurers - biannual fee - auto theft prevention authority. (1) Each insurer that issues a policy pursuant to this part 6 shall biannually pay a fee to the automobile theft prevention board, created pursuant to section 42-5-112, C.R.S., for the support of the automobile theft prevention authority. Upon receiving payment, the board shall transfer the amount received to the state treasurer for deposit in the Colorado auto theft prevention cash fund created in section 42-5-112 (4), C.R.S. The amount of the fee shall be equal to one dollar multiplied by the number of motor vehicles insured by the insurer as of July 1 of each year, divided by two. The insurer shall report the number of insured motor vehicles and pay the assessed biannual fee as follows:

(a) On or before August 15, 2008, and on or before August 15 each year thereafter, the insurer shall notify the automobile theft prevention board of the number of motor vehicles insured by that insurer as of July 1 of that year; and

(b) On or before January 1, 2009, and July 1, 2009, and on or before January 1 and July 1 each year thereafter, the insurer shall pay to the automobile theft prevention board the assessed biannual fee in the amount specified in this subsection (1).

(2) On or before February 1, 2009, and on or before February 1 each year thereafter, the automobile theft prevention board shall compare the list of insurers who paid the biannual fee with the list compiled by the division of insurance of all insurance companies licensed to insure motor vehicles in the state and shall notify the commissioner of the division of insurance of any

insurer's failure to pay the fee prescribed in subsection (1) of this section. Upon receiving notice of an insurer's failure to pay the fee, the commissioner shall notify the insurer of the fee requirement. If the insurer fails to pay the fee to the automobile theft prevention board within fifteen days after receiving the notice, the commissioner may suspend the insurer's certificate of authority or impose a civil penalty of not more than one hundred twenty percent of the amount due, or both. The insurer shall pay the civil penalty to the commissioner. The commissioner shall transfer the amount received to the state treasurer who shall credit the amount to the Colorado auto theft prevention cash fund, created in section 42-5-112 (4), C.R.S.

(3) For the purposes of this section, "insurer" shall have the same meaning as provided in section 10-1-102 (13) that covers the operation of a motor vehicle.

(4) (a) Each insurer subject to the provisions of this section is hereby authorized to recoup the fee required in subsection (1) of this section from its policyholders.

(b) Each insurer subject to the provisions of this section shall not raise its premiums based on the fee in this section.

(5) As used in this section, "motor vehicle" does not include vehicles or vehicle combinations with a declared gross weight of more than twenty-six thousand pounds.

Source: L. 2003: Entire section added, p. 1330, § 2, effective April 22. **L. 2008:** Entire section amended, p. 2098, § 4, effective July 1. **L. 2009:** IP(1) and (2) amended, (SB 09-292), ch. 369, p. 1943, § 13, effective August 5.

Editor's note: This section was originally numbered as § 10-4-616 in House Bill 03-1251 but has been renumbered on revision for ease of location.

Cross references: For the legislative declaration contained in the 2008 act amending this section, see section 1 of chapter 415, Session Laws of Colorado 2008.

10-4-618. Unfair or discriminatory trade practices - legislative declaration. (Repealed)

Source: L. 2003: Entire section added, p. 2554, § 2, effective July 1. **L. 2007:** Entire section repealed, p. 974, § 2, effective May 18.

10-4-619. Coverage compulsory. (1) Every owner of a motor vehicle who operates the motor vehicle on the public highways of this state or who knowingly permits the operation of the motor vehicle on the public highways of this state shall have in full force and effect a complying policy under the terms of this part 6 covering the said motor vehicle, and any owner who fails to do so shall be subject to the sanctions provided under sections 42-4-1409 and 42-7-301, C.R.S., of the "Motor Vehicle Financial Responsibility Act". This section shall not apply to persons who hold a current and valid certificate of self-insurance pursuant to section 10-4-624.

(2) An insurer shall not refuse to provide benefits to an insured on the basis that the insured is a volunteer for a fire department and is injured in a motor vehicle while responding to an emergency.

Source: L. 2003: Entire section amended, p. 2433, § 2, effective June 5; entire section added, p. 1560, § 3, effective July 1. **L. 2004:** Entire section amended, p. 895, § 3, effective May 21.

Editor's note: This section was originally numbered as § 10-4-616 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-620. Required coverage. Subject to the limitations and exclusions authorized by this part 6, the basic coverage required for compliance with this part 6 is legal liability coverage for bodily injury or death arising out of the use of the motor vehicle to a limit, exclusive of interest and costs, of twenty-five thousand dollars to any one person in any one accident and fifty thousand dollars to all persons in any one accident and for property damage arising out of the use of the motor vehicle to a limit, exclusive of interest and costs, of fifteen thousand dollars in any one accident.

Source: L. 2003: Entire section added, p. 1561, § 3, effective July 1.

Editor's note: This section was originally numbered as § 10-4-617 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-621. Required coverages are minimum. (1) Nothing in this part 6 shall be construed to prohibit the issuance of policies providing coverages more extensive than the minimum coverage required by section 10-4-620, nor to require the segregation of such minimum coverage from other coverages in the same policy. However, loss statistics as to bodily injury liability and property damage liability shall be kept separately for rating purposes, and such statistics shall be filed with the commissioner each year.

(2) On and after January 1, 2005, all insurers shall offer collision coverage for damage to insured motor vehicles subject to deductibles of one hundred dollars and two hundred fifty dollars. Insurers may offer such other reasonable deductibles as they deem appropriate. Collision coverage shall provide insurance without regard to fault against accidental property damage to the insured motor vehicle with another motor vehicle or motor vehicle caused by physical contact of the insured with another object or by upset of the insured motor vehicle, if the accident occurs within the United States or its territories or possessions.

(3) No insurer may surcharge, refuse to write, cancel, or nonrenew a complying policy of automobile insurance based solely on the method of compliance or level of coverage chosen, as long as the requirements are met under section 42-3-105 (1)(d)(I) or (1)(f), C.R.S.

Source: L. 2003: Entire section added, p. 1561, § 3, effective July 1. **L. 2004:** (2) amended, p. 173, § 1, effective January 1, 2005. **L. 2006:** (3) amended, p. 1491, § 14, effective June 1.

Editor's note: This section was originally numbered as § 10-4-618 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-622. Required provision for intrastate and interstate operation. (1) Notwithstanding any of its terms and conditions, every complying policy shall afford coverage at least as extensive as the minimum coverage required by section 10-4-620.

(2) Nothing in this section shall be construed to require that a complying policy provide coverage while the insured motor vehicle is operated in other jurisdictions by reason of any program, statute, law, or administrative rule in effect in such other jurisdiction by which coverage is afforded in such other jurisdiction through a government agency or publicly financed auto accident reparations plan such as, by way of illustration and not limitation, plans presently in effect in the province of Saskatchewan, Canada, and the commonwealth of Puerto Rico, U.S.A.

(3) On and after January 1, 2005, notwithstanding any of its other terms and conditions, every complying policy shall afford coverage at least as extensive as the minimum coverage required by operation of section 10-4-620, during such periods of time as the insured motor vehicle is operated in other jurisdictions of the United States or its territories or possessions, as the statutes, laws, or administrative rules of such other jurisdictions require with respect to liability or financial responsibility and direct benefit or first-party coverages for operators, occupants, and persons involved in accidents arising out of use or operation of motor vehicles within such other jurisdictions.

(4) (a) Notwithstanding any of its other terms and conditions, every contract of liability insurance for injury, wherever issued, covering ownership, maintenance, or use of a motor vehicle, shall provide coverage at least as extensive as the minimum coverages required by operation of section 10-4-620, and qualifies as security covering the vehicle while it is in this state.

(b) An insurer authorized to transact or transacting business in this state may not exclude the minimum coverage required by operation of section 10-4-620 in any contract of liability insurance for injury, wherever issued, covering ownership, maintenance, or use of a motor vehicle while it is in this state.

Source: L. 2003: Entire section added, p. 1561, § 3, effective July 1. **L. 2004:** (2) amended, p. 902, § 22, effective May 21; (3) amended, p. 173, § 2, effective January 1, 2005.

Editor's note: This section was originally numbered as § 10-4-619 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-623. Conditions and exclusions. (1) The coverage described in section 10-4-620 may be subject to conditions and exclusions that are not inconsistent with the requirements of this part 6.

(2) The coverage described in section 10-4-620 may also be subject to exclusions where the injured person:

(a) Sustains injury caused by his or her own intentional act; or

(b) Is operating a motor vehicle as a converter without a good faith belief that he or she is legally entitled to operate or use such vehicle.

(3) (a) The coverage described in section 10-4-620 is conditioned upon the insurer offering coverages pursuant to section 10-4-609 (1).

(b) The insurer shall be deemed to have complied with the requirements of section 10-4-609 (1) and the exclusion of the insured from uninsured motorist coverage shall be deemed valid if the named insured has rejected the uninsured motorist coverage in writing. Such exclusion shall be continuing until such time as the insured requests that the insurer provide uninsured motorist coverage. The insurer shall not have a duty to offer uninsured motorist coverage after receiving the insured's written request for exclusion even though:

(I) The vehicles insured under the policy have changed; or

(II) The policy is reinstated, transferred, substituted, amended, altered, modified, replaced, or renewed.

(c) The insurer shall be deemed to have complied with section 10-4-609 (1) and the insured's uninsured motorist coverage shall be deemed valid if the insurer has offered coverage at available levels and the insured has selected coverage of a certain value. The insurer shall not have a duty to offer changes in uninsured motorist coverage to the insured even though:

(I) The vehicles covered under the policy have changed; or

(II) The policy is reinstated, transferred, substituted, amended, altered, modified, replaced, or renewed; except that, if there is an increase in bodily injury liability limits and the limits of the uninsured motorist coverage would be less than such limits, the insurer shall offer new uninsured motorist coverage to the insured pursuant to section 10-4-609 (2).

Source: L. 2003: Entire section added, p. 1562, § 3, effective July 1.

Editor's note: This section was originally numbered as § 10-4-620 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-624. Self-insurers. (1) Any person in whose name more than twenty-five motor vehicles are registered may qualify as a self-insurer by obtaining a certificate of self-insurance issued by the commissioner.

(2) The commissioner may, in his or her discretion, upon the application of such person, issue a certificate of self-insurance when the commissioner is satisfied that such person is able and will continue to be able to pay benefits as required under section 10-4-620 and to pay any and all judgments that may be obtained against such person. Upon not less than five days' notice and a hearing pursuant to such notice, the commissioner may, upon reasonable grounds, cancel a certificate of self-insurance. Failure to pay any benefits under section 10-4-620 or failure to pay any judgment within thirty days after such judgment has become final shall constitute a reasonable ground for the cancellation of a certificate of self-insurance.

(3) For purposes of subsection (2) of this section, the commissioner shall accept, as proof that a motor carrier as defined in article 10.1 of title 40, C.R.S., is able and will continue to be able to pay all judgments that might be obtained against the carrier, a surety bond in a form acceptable to the commissioner in an amount determined by the commissioner sufficient to ensure that the carrier has the ability to pay all judgments that may be obtained against any such carrier.

Source: L. 2003: (2) amended, p. 2433, § 3, effective June 5; entire section added, p. 1563, § 3, effective July 1. **L. 2011:** (3) amended, (HB 11-1198), ch. 127, p. 417, § 6, effective August 10.

Editor's note: This section was originally numbered as § 10-4-621 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-625. Premium payments. The commissioner shall issue rules establishing monthly, quarterly, semiannual, and annual premium payments for persons who are required to purchase insurance under this part 6. An insurer providing a plan for payments on a basis that is more frequent than quarterly need not also provide a quarterly payment plan. An insurer's plan for payments may provide for payment of an advance deposit premium.

Source: L. 2003: Entire section added, p. 1563, § 3, effective July 1. **L. 2008:** Entire section amended, p. 386, § 1, effective August 5.

Editor's note: This section was originally numbered as § 10-4-622 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-626. Prohibited reasons for nonrenewal or refusal to write policy of automobile insurance applicable to this part 6. (1) An insurer authorized to transact or transacting business in this state shall not refuse to write or refuse to renew a policy of insurance affording the coverage required by section 10-4-620 solely because of the age, race, creed, color, religion, sex, sexual orientation, gender identity, gender expression, national origin, ancestry, residence, marital status, or lawful occupation, including the military service, of anyone who is or seeks to become insured or solely because another insurer has canceled a policy or refused to write or renew such policy. The commissioner shall administer and enforce this subsection (1).

(2) Nothing in this section shall be construed to prohibit an insurance company authorized to transact or transacting business in this state from issuing policies of insurance affording the coverage required by operation of section 10-4-620 solely to a specialty market authorized by the commissioner.

Source: L. 2003: Entire section added, p. 1563, § 3, effective July 1. **L. 2008:** (1) amended, p. 1599, § 13, effective May 29. **L. 2021:** (1) amended, (HB 21-1108), ch. 156, p. 890, § 15, effective September 7.

Editor's note: This section was originally numbered as § 10-4-623 in House Bill 03-1188 but has been renumbered on revision for ease of location.

Cross references: For the legislative declaration contained in the 2008 act amending subsection (1), see section 1 of chapter 341, Session Laws of Colorado 2008. For the legislative declaration in HB 21-1108, see section 1 of chapter 156, Session Laws of Colorado 2021.

10-4-627. Discriminatory standards - premiums - surcharges - proof of financial responsibility requirements. (1) An insurer shall not:

(a) Cancel or nonrenew, or increase the premium of, a policy of insurance on a motor vehicle used by any resident of the household of the named insured solely because of convictions for traffic violations that resulted in less than seven points being assessed under the point system schedule set forth in section 42-2-127 (5), C.R.S., resulting from violations while in the course

of employment while the insured is driving a motor vehicle used primarily as a public or livery conveyance or licensed as a commercial vehicle; or

(b) Add a surcharge to the policy premium of an insured or a family member of an insured or other person living in the same household as an insured in a manner that results in an excessive or unfairly discriminatory premium pursuant to section 10-4-403.

(2) This section shall not be construed to limit or in any manner restrict an insurer from canceling or refusing to issue or renew a policy of insurance or from increasing the premium of an insured on a motor vehicle used by him or her for commercial purposes or from reclassifying an insured for traffic violations received by the insured while using a motor vehicle for commercial purposes.

Source: L. 2003: Entire section added, p. 1564, § 3, effective July 1.

Editor's note: This section was originally numbered as § 10-4-624 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-628. Refusal to write - changes in - cancellation - nonrenewal of policies prohibited. (1) No insurer shall cancel; fail to renew; refuse to write; reclassify an insured under; reduce coverage under, unless the reduction is part of a general reduction in coverage filed with the commissioner; or increase the premium for, unless the increase is part of a general increase in premiums filed with the commissioner, any complying policy because the applicant, insured, permissive user, or any resident of the household of the applicant or insured has:

(a) Had an accident or accidents that are not the fault of such named applicant, insured, household member, or permissive user;

(b) Had a license suspended pursuant to section 42-2-127.5, C.R.S., or been denied a license pursuant to section 42-2-104 (3)(f), C.R.S.

(2) (a) (I) No insurer shall cancel; fail to renew; reclassify an insured under; reduce coverage under, unless the reduction is part of a general reduction in coverage filed with the commissioner; or increase the premium for, unless the increase is part of a general increase in premiums filed with the commissioner, any complying policy solely because the insured person has been convicted of an offense related to the failure to have in effect compulsory motor vehicle insurance or because such person has been denied issuance of a motor vehicle registration for failure to have such insurance.

(II) Unless actuarial justification in support of the insurer's action that has been filed with the commissioner demonstrates that there is an increase in risk, no insurer shall refuse to write a policy for a new applicant, surcharge the premium of a new applicant, or place a new applicant in a higher-priced program or plan based solely upon:

(A) The fact that the applicant had no prior insurance;

(B) The identity of the applicant's prior insurer; or

(C) The applicant's prior type of coverage, including assigned risk or residual market coverage or any plan other than a preferred plan.

(III) An insurer may use industry-wide data in its actuarial justification under subparagraph (II) of this paragraph (a).

(IV) An insurer shall not refuse to write a policy for a new applicant, surcharge the premium of a new applicant, or place a new applicant in a higher-priced program or plan solely

because the applicant had no prior insurance if the applicant was not required to have insurance under section 10-4-620 or under a similar law in another state.

(V) An insurer shall not reduce or cancel insurance coverage except for nonpayment, refuse to issue or renew a policy, or surcharge a newly issued or renewed policy due to a covered person's failure to maintain coverage during a period in which the covered person was deployed by or called to active duty in the United States military if the person was not required to maintain insurance under section 10-4-619 or under a similar law of another state.

(b) (I) An insurer shall not refuse to write a complying policy solely because of the claim or driving record of one or more but fewer than all of the persons residing in the household of the named insured.

(II) An insurer shall offer to exclude any person in a household by name pursuant to section 10-4-630 if such person's driving record and claim experience would justify the refusal by such insurer to write a policy for such person if such person were applying in such person's own name and not as part of a household.

(III) An insurer renewing a policy pursuant to subparagraph (II) of this paragraph (b) shall include, as part of such renewal, a written notice naming the party specifically excluded from coverage.

(3) An insured who believes subsection (1) or (2) of this section have been violated has the right to file a complaint with the division of insurance pursuant to section 10-4-629.

(4) The commissioner shall promulgate rules to implement this section.

Source: L. 2003: Entire section added, p. 1564, § 3, effective July 1. **L. 2004:** (2)(b)(II) and (3) amended, p. 1189, § 13, effective August 4. **L. 2005:** (2)(a)(V) added, p. 220, § 1, effective April 14. **L. 2009:** (1)(b) amended, (HB 09-1266), ch. 347, p. 1816, § 7, effective August 5. **L. 2012:** (3) amended, (HB 12-1289), ch. 95, p. 313, § 2, effective August 8.

Editor's note: This section was originally numbered as § 10-4-625 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-629. Cancellation - renewal - reclassification. (1) Except in accordance with the provisions of this part 6, an insurer shall not cancel or fail to renew a policy of insurance that complies with this part 6, issued in this state, as to any resident of the household of the named insured, for any reason other than nonpayment of premium, or increase a premium for any coverage on any such policy unless the increase is part of a general increase in premiums filed with the commissioner and does not result from a reclassification of the insured, or reduce the coverage under any such policy unless the reduction is part of a general reduction in coverage filed with the commissioner or to satisfy the requirements of other sections of this part 6.

(2) An insurer intending to take an action subject to this section shall, on or before the thirtieth day before the effective date of the intended action, send written notice by United States mail of its intended action to the insured at the insured's last-known address. The insurer may include the notice of the intended action in the renewal documents, nonrenewal, or cancellation notice provided to the policyholder, as applicable. The notice must state in clear and specific terms, on a form for which the insurer has filed a certification with the commissioner that such notice form conforms to Colorado law and any rules promulgated by the commissioner:

(a) The proposed action to be taken, including, if the action is an increase in premium or reduction in coverage, the amount of increase and the type of coverage to which it is applicable or the type of coverage reduced and the extent of the reduction;

(b) The proposed effective date of the action;

(c) The insurer's actual reasons for proposing to take such action. The statement of reasons shall be sufficiently clear and specific so that a person of average intelligence can identify the basis for the insurer's decision without making further inquiry. Generalized terms such as "personal habits", "living conditions", "poor morale", or "violation or accident record" shall not suffice to meet the requirements of this subsection (2).

(d) If there is coupled with the notice an offer to continue or renew the policy in accordance with this section, the name of the person or persons to be excluded from coverage and what the premium would be if the policy is continued or renewed with such person or persons excluded from coverage;

(e) The right of the insured to replace the insurance through an assigned risk plan;

(f) The right of the insured to file a complaint with the division of insurance regarding the action that is the subject of the notice.

(g) and (h) Repealed.

(3) Any statement of reasons contained in the notice given pursuant to paragraph (c) of subsection (2) of this section shall be privileged and shall not constitute grounds for any action against the insurer or its representatives or any person who in good faith furnished to the insurer the information upon which the statement is based.

(4) to (8) Repealed.

(9) This section does not apply to an insurance policy or coverage that has been in effect less than sixty days at the time the insurer mails or delivers the notice of cancellation, nonrenewal, or reclassification, unless it is a renewal policy.

Source: L. 2003: Entire section added, p. 1566, § 3, effective July 1. **L. 2004:** (6) amended, p. 178, § 1, effective July 1; (2)(d) amended, p. 1190, § 14, effective August 4. **L. 2010:** (6) amended, (HB 10-1220), ch. 197, p. 853, § 14, effective July 1. **L. 2012:** IP(2), (2)(f), and (9) amended and (2)(g), (2)(h), and (4) to (8) repealed, (HB 12-1289), ch. 95, p. 311, § 1, effective August 8.

Editor's note: This section was originally numbered as § 10-4-626 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-630. Exclusion of named driver. (1) In any case where an insurer is authorized under this part 6 to cancel or refuse to renew or increase the premiums on an automobile liability insurance policy under which more than one person is insured because of the claim experience or driving record of one or more but less than all of the persons insured under the policy, the insurer shall in lieu of cancellation, nonrenewal, or premium increase offer to continue or renew the insurance but to exclude from coverage, by name, the person whose claim experience or driving record would have justified the cancellation or nonrenewal. The premiums charged on any such policy excluding a named driver shall not reflect the claims, experience, or driving record of the excluded named driver.

(2) With respect to any person excluded from coverage under this section, the policy may provide that the insurer shall not be liable for damages, losses, or claims arising out of this operation or use of the insured motor vehicle, whether or not such operation or use was with the express or implied permission of a person insured under the policy.

Source: L. 2003: Entire section added, p. 1568, § 3, effective July 1.

Editor's note: This section was originally numbered as § 10-4-627 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-631. Insurers to file rate schedule. (Repealed)

Source: L. 2003: Entire section added, p. 1568, § 3, effective July 1. **L. 2017:** Entire section repealed, (SB 17-249), ch. 283, p. 1548, § 17, effective June 1.

10-4-632. Reduction in rates for drivers aged fifty-five years or older who complete driver's education course - legislative declaration. (1) (a) (I) The general assembly finds and determines that motor vehicle accidents cause a substantial economic impact in lost wages, medical bills, legal fees, rehabilitation costs, and higher insurance rates.

(II) The general assembly also finds that the motor vehicle accident rate creates an additional societal burden in the form of taxes for medicaid, for the medically indigent, and for other hospital-related costs.

(III) The general assembly further finds that the number of such accidents and injuries is positively affected when drivers fifty-five years of age or older take driver's education courses.

(b) Therefore, the general assembly declares that it is appropriate and beneficial to all the people of Colorado that drivers fifty-five years of age or older with recent training and good driving records pay experience-based insurance premiums.

(c) A financial incentive in the form of lower premiums will prompt drivers fifty-five years of age or older to take driver's education courses and will further the goal of the general assembly to reduce accident-related injuries and fatalities in Colorado.

(2) All rates, rating schedules, and rating manuals for liability and collision coverages of a motor vehicle insurance policy submitted to or filed with the commissioner under this part 6 shall provide for an appropriate reduction in premium charges based on justifiable data when the vehicle is a covered vehicle and when the principal operator is fifty-five years of age or older and has successfully completed a driver's education course taught by a driving school regulated pursuant to part 6 of article 2 of title 42 or by a nonprofit corporation subject to articles 121 to 137 of title 7, if such course has been preapproved by the department of revenue. Any discount used by an insurer shall be presumed appropriate unless credible data demonstrates otherwise. Insurers shall provide the commissioner with data reflecting the claims experience of drivers who have received reductions in premium charges compared with the claims experience of drivers who have not received such reductions.

(3) Each person who successfully completes a driver's education course taught by a commercial driving school regulated pursuant to part 6 of article 2 of title 42 shall be issued a certificate by the commercial driving school offering the course, which certificate shall be evidence of qualification for the premium discount required by this section.

(4) Each person who successfully completes a driver's education course taught by a nonprofit corporation subject to articles 121 to 137 of title 7, C.R.S., if such course has been preapproved by the department of revenue, shall be issued a certificate by the nonprofit corporation offering the course, which certificate shall be evidence of qualification for the premium discount required by this section.

(5) The premium reduction required by this section shall be effective for an insured for a three-year period after successful completion of the approved course. However, the insurer may require, as a condition of providing and maintaining such discount, that the insured, during the three-year period after course completion, not be involved in an accident for which the insured is held at fault.

(6) An insured may renew qualification for the discount provided by this section by:

(a) (I) Retaking a driver's education course taught by a commercial driving school regulated pursuant to part 6 of article 2 of title 42; or

(II) Retaking a driver's education course taught by a nonprofit corporation subject to articles 121 to 137 of title 7, C.R.S., if such course has been preapproved by the department of revenue; and

(b) Not being involved in an accident for which the insured is held at fault.

(7) This section shall not apply where an insured driver is taking a driver's education course as a result of an order of a court or other governmental entity resulting from a moving traffic violation.

Source: L. 2003: Entire section added, p. 1568, § 3, effective July 1. **L. 2017:** (2), (3), and (6)(a)(I) amended, (SB 17-224), ch. 179, p. 659, § 2, effective August 9.

Editor's note: This section was originally numbered as § 10-4-629 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-633. Certification of policy and notice forms. (1) All insurers providing automobile insurance and who are authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy forms, endorsements, cancellation notices, renewal notices, disclosure forms, notices of proposed premium increases, notices of proposed reductions in coverage, and such other forms as may be requested by the commissioner issued or delivered to any policyholder in Colorado. Such listing shall be submitted no later than July 1 of each year and shall contain a certification by an officer of the organization that to the best of the officer's knowledge each policy form, endorsement, or notice form in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

(2) All insurers providing automobile insurance and who are authorized by the commissioner to conduct business in Colorado shall also submit to the commissioner a list of any new policy form, endorsement, cancellation notice, renewal notice, disclosure form, notice of proposed premium increase, notice of proposed reductions in coverage, and any other form as may be requested by the commissioner at least thirty-one days before using such policy form, endorsement, cancellation notice, renewal notice, disclosure form, notice of proposed premium increase, notice of proposed reductions in coverage, and any other form as may be requested by the commissioner. Such listing shall also contain a certification by an officer of the organization

that to the best of the officer's knowledge each new policy form, endorsement, or notice form proposed to be used complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

(3) The commissioner shall have the power to examine and investigate insurers authorized to conduct business in Colorado to determine whether automobile policy forms, endorsements, cancellation notices, renewal notices, disclosure forms, notices of proposed premium increases, notices of proposed reductions in coverage, and such other forms as may be requested by the commissioner comply with the certification of the organization and statutory mandates.

Source: L. 2003: Entire section added, p. 1570, § 3, effective July 1.

Editor's note: This section was originally numbered as § 10-4-630 in House Bill 03-1188 but has been renumbered on revision for ease of location.

10-4-633.5. Automobile insurance policies - plain language required - rules. (1) (a) An insurer issuing or renewing automobile insurance policies subject to this part 6 shall not issue or renew a policy unless the text of the policy form does not exceed the tenth-grade level, as measured by the Flesch-Kincaid grade level formula, or does not score less than fifty as measured by the Flesch reading ease formula.

(b) In conjunction with the report submitted to the commissioner pursuant to section 10-4-633, the insurer shall report the readability scores prior to the issuance or renewal of a policy or the use of the policy form.

(2) The policy form shall contain an index or table of contents if the policy is more than three pages in length or if the text of the policy exceeds three thousand words. The index, table of contents, and text of the policy form shall be printed in not less than ten-point type.

(3) For purposes of subsections (1) and (2) of this section, the following shall apply:

(a) (I) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall count as one word;

(II) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and

(III) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciations containing fewer syllables may be used.

(b) "Text" includes all printed matter except the following:

(I) The name and address of the insurer; the name, number, or title of the policy; the table of contents or index; captions and subcaptions; and specification pages, schedules, or tables; and

(II) Any policy language that is drafted to conform to the requirements of any federal law or regulation; any policy language required by any collectively bargained agreement; any medical terminology; any words that are defined in the policy; and any policy language required by law or regulation if the insurer identifies the language or terminology excepted and certifies in writing that the language or terminology is entitled to be excepted.

(4) The commissioner shall promulgate rules regarding the electronic dissemination of newly issued or renewed policy forms or endorsements.

(5) (a) The requirements of this section shall not apply to commercial automobile insurance coverage.

(b) For the purpose of this subsection (5), "commercial automobile insurance coverage" means any insurance coverage provided to an insured, regardless of the number of vehicles or entities covered, under a commercial automobile, garage, motor carrier, or truckers coverage policy form and rated using either a commercial manual or rating rule.

Source: L. 2010: Entire section added, (HB 10-1166), ch. 143, p. 486, § 1, effective January 1, 2012. **L. 2013:** IP(3) amended, (HB 13-1300), ch. 316, p. 1664, § 13, effective August 7.

10-4-634. Assignment of payment for covered benefits. (1) A policy of motor vehicle insurance coverage pursuant to this part 6 shall allow, but not require, an insured under the policy to assign, in writing, payments due under medical payments coverage of the policy to a licensed hospital or other licensed health-care provider; an occupational therapist, as defined in section 12-270-104 (9); an occupational therapy assistant, as defined in section 12-270-104 (11); or a massage therapist, as defined in section 12-235-104 (5), for services provided to the insured that are covered under the policy.

(2) When a licensed hospital or other licensed health-care provider, occupational therapist, or massage therapist receives an assignment from an insured, it is the responsibility of the provider to bill the insurer and notify the insurer that the licensed health-care provider holds an assignment on file. The insurer shall honor this assignment the same as if a copy of the assignment had been received by the insurer. Only upon request of the insurer shall the health-care provider be required to provide a copy of the assignment. The provider shall also provide a copy of such bill to the insured, stating on such copy that it is for informational purposes only and that the insurer has been billed for covered benefits. The provider shall also furnish to the insurer a current taxpayer identification number as part of the initial bill and each subsequent billing. Subsequent billings to an insurer need not include a copy of the assignment unless required by the insurer so long as it is clearly noted on each such subsequent billing that the benefits have been assigned. The insurer shall honor such assignment and make payment of covered benefits directly to such licensed hospital or other licensed health-care provider, occupational therapist, or massage therapist. If the insurer fails to honor such assignment but instead makes payment to the insured, and if the insured fails to timely pay an amount equivalent to such payment to the licensed hospital or other licensed health-care provider, then the insurer shall be liable for such payment directly to the licensed hospital or other licensed health-care provider, occupational therapist, or massage therapist. It shall be the responsibility of the licensed hospital or other licensed health-care provider, occupational therapist, or massage therapist to notify the insurer if timely payment has not been received.

Source: L. 2004: Entire section added, p. 250, § 1, effective April 5. **L. 2008:** (1) amended, p. 830, § 5, effective July 1. **L. 2009:** (1) amended, (SB 09-292), ch. 369, p. 1943, § 14, effective August 5. **L. 2010:** (1) amended, (HB 10-1220), ch. 197, p. 855, § 19, effective July 1. **L. 2019:** (1) amended, (HB 19-1172), ch. 136, p. 1651, § 34, effective October 1. **L. 2021:** (1) amended, (SB 21-003), ch. 4, p. 28, § 2, effective January 21.

10-4-635. Medical payments coverage - exceptions - definitions. (1) (a) Except as otherwise provided in this subsection (1), no automobile liability or motor vehicle liability policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle shall be delivered or issued for delivery in this state unless coverage is provided in the policy or in a supplemental policy for medical payments with benefits of five thousand dollars for bodily injury, sickness, or disease resulting from the ownership, maintenance, or use of the motor vehicle.

(b) A policy may be issued without medical payments coverage only if the named insured rejects medical payments coverage in writing or in the same medium in which the application for the policy was taken. The insurer shall maintain proof that a named insured rejected medical payments coverage for at least three years after the date of the rejection, and such proof of rejection shall be presumed valid for all insureds under the policy, including resident relatives of the named insured and permissive users of the motor vehicle. An agent or insurer that obtains a rejection of medical payments coverage from the named insured or applicant pursuant to this section shall not be liable to the insured or any other person seeking benefits under the named insured's policy for claims arising out of or relating to the rejection of medical payments coverage.

(c) If the insurer fails to offer medical payments coverage or fails to maintain or provide proof that the named insured rejected medical payments coverage in the manner required by this section, the insured's policy shall be presumed to include medical payments coverage with benefits of five thousand dollars.

(d) If an insured selects limits for medical payments coverage or exercises the option not to purchase the coverages described in this section, an insurer or affiliated insurer shall not be required to notify any policyholder in any renewal or replacement policy of the availability of medical payments coverage. However, the insured may make a request for additional coverage or coverage more extensive than that provided on a prior policy.

(e) Nothing in this section shall be construed to limit any other coverage amounts being made available by an insurer.

(2) (a) If a policy contains medical payments coverage, medical payments benefits shall be paid to persons providing medically necessary and accident-related trauma care or medical care. Except as provided in paragraphs (b), (c), and (d) of this subsection (2), payments of claims for medical payments coverage shall be made in accordance with section 10-4-642.

(b) Upon receiving notice, either from a provider or the insured, of an accident for which the medical payments coverage specified in this section or medical payments coverage in a greater amount may apply, the insurer shall reserve five thousand dollars of the medical payments coverage for the payment of trauma care provided by a licensed air ambulance, licensed ambulance, trauma physician, or trauma center in the following priority, as applicable:

(I) Benefits shall be paid first to licensed ambulances or air ambulances that provide trauma care at the scene of or immediately after the motor vehicle accident, including transport to or from a trauma center.

(II) After payments to providers described in subparagraph (I) of this paragraph (b), benefits shall be paid next to trauma physicians that provide trauma care to stabilize or provide the first episode of care to the injured person.

(III) After payments to providers described in subparagraphs (I) and (II) of this paragraph (b), benefits shall be paid next to trauma centers designated as level IV or V pursuant to section 25-3.5-703 (4), C.R.S., that provide trauma care to stabilize or provide the first episode of care to the injured person.

(IV) After payments to providers described in subparagraphs (I), (II), and (III) of this paragraph (b), benefits shall be paid next to trauma centers designated as level I, II, or III or as a regional pediatric trauma center pursuant to section 25-3.5-703 (4), C.R.S., that provide trauma care to stabilize or provide the first episode of care to the injured person.

(c) The reserve shall be held and used to pay claims of trauma care providers described in this subsection (2) for no more than thirty days after receipt of the accident notice. After the thirty-day period, any amount of the reserve for which the insurer has not received a claim for reimbursement from a trauma care provider described in this subsection (2) may be used to pay any other claims for reimbursement submitted by other providers.

(d) The periods specified in section 10-4-642 for the prompt payment of medical payments coverage benefits shall be tolled for the period that an insurer is required under this subsection (2) to hold payment of a claim from a provider that did not provide trauma care, but only to the extent the medical payments coverage benefits not held in reserve are insufficient to pay the claim.

(3) (a) An insurer providing benefits under medical payments coverage in the amount specified in this section or in a greater amount than the amount specified in this section shall not have a right to recover against an owner, user, or operator of a motor vehicle, or against any person or organization legally responsible for the acts or omissions of such person, in any action for damages for benefits paid under such medical payments coverage. An insurer shall not have a direct cause of action against an alleged tortfeasor for benefits paid under medical payments coverage.

(b) Nothing in this subsection (3) shall be construed to:

(I) Modify the requirements of section 13-21-111.6, C.R.S., or any requirements under the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S.;

(II) Prevent a person to whom benefits are paid under medical payments coverage from obtaining recovery of benefits available under uninsured motorist coverage pursuant to section 10-4-609; or

(III) Afford an insurer a cause of action against a person to whom or for whom the medical payments coverage benefits specified in this section were paid except in a case where the benefits were paid by reason of fraud.

(4) This section does not apply to:

(a) A person obtaining an automobile liability or motor vehicle policy insuring against loss resulting from the ownership, maintenance, or use of a motorcycle, autocycle, low-power scooter, or toy vehicle, as defined in section 42-1-102; a snowmobile, as defined in section 33-14-101; or any vehicle designed primarily for use off the road or on rails;

(b) A person that has obtained a certificate of self-insurance from the commissioner pursuant to section 10-4-624.

(5) As used in this section:

(a) "Injured person" means the insured, or a passenger who is authorized by the insured to occupy the insured's motor vehicle, who sustains bodily injury arising out of the use of the insured's motor vehicle.

(b) "Licensed air ambulance" means an air ambulance, as defined in section 25-3.5-103 (1), C.R.S., that is licensed by the department of public health and environment pursuant to section 25-3.5-307, C.R.S.

(c) "Licensed ambulance" means an ambulance, as defined in section 25-3.5-103 (1.5), C.R.S., that is licensed pursuant to section 25-3.5-301, C.R.S.

(d) "Licensed health-care provider" has the same meaning as set forth in section 10-4-601, and also includes an occupational therapist, as defined in section 12-270-104 (9), and an occupational therapy assistant, as defined in section 12-270-104 (11).

(e) "Medical care" means all medically necessary and accident-related health-care and rehabilitation services provided by a licensed health-care provider to a person injured in an automobile accident for which benefits under the terms of the medical payments coverage in the policy are payable.

(f) "Provider" means a licensed health-care provider, licensed air ambulance, licensed ambulance, trauma physician, or trauma center.

(g) "Stabilize" means, with respect to a medical condition resulting from a trauma, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer of the individual to or from a trauma center.

(h) "Trauma" means an injury or wound to a living person caused by the application of an external physical force. Trauma includes any event that threatens life, limb, or the well-being of an individual in such a manner that a prudent lay person would believe that immediate medical care is needed.

(i) "Trauma care" means care provided by a licensed ambulance or air ambulance, trauma physician, or trauma center to a person injured in a motor vehicle accident from the time the administration of care begins to the time the patient is fully stabilized or through the first episode of care, not to exceed seventy-two hours after the administration of care begins. The term includes a trauma care system, trauma transport protocols, and triage, as defined in section 25-3.5-703, C.R.S.

(j) "Trauma center" means the emergency department in a licensed or certified hospital or a health-care facility that is designated by the department of public health and environment as a level I, II, III, IV, or V facility or as a regional pediatric trauma center.

(k) "Trauma physician" means a trauma surgeon, orthopedic surgeon, neurosurgeon, intensive care unit physician, anesthesiologist, or physician who provides care in a trauma center to a trauma patient injured in a motor vehicle accident.

Source: L. 2004: Entire section added, p. 415, § 1, effective July 1. **L. 2005:** Entire section amended, p. 467, § 1, effective January 1, 2006. **L. 2006:** (2) repealed, p. 38, § 3, effective January 1, 2007. **L. 2008:** Entire section amended, p. 2261, § 1, effective January 1, 2009. **L. 2009:** (5)(d) amended, (SB 09-292), ch. 369, p. 1943, § 15, effective August 5; (4)(a) amended, (HB 09-1026), ch. 281, p. 1253, § 2, effective October 1. **L. 2010:** (5)(d) amended, (HB 10-1220), ch. 197, p. 855, § 20, effective July 1. **L. 2019:** (5)(d) amended, (HB 19-1172), ch. 136, p. 1652, § 35, effective October 1. **L. 2021:** (5)(d) amended, (SB 21-003), ch. 4, p. 28, § 3, effective January 1. **L. 2022:** IP(4) and (4)(a) amended, (HB 22-1043), ch. 361, p. 2582, § 6, effective January 1, 2023.

10-4-636. Disclosure requirements for automobile insurance products offered - rules. (1) (a) An insurer or producer issuing automobile insurance policies shall, as a condition of doing business in this state, have on file for public inspection at the division a summary disclosure form that contains an explanation of the major coverages and exclusions of such policies of insurance together with a recitation of general factors considered in cancellation, nonrenewal, and increase-in-premium situations. Each summary disclosure form shall provide notice in bold-faced letters that the policyholder should read the policy for complete details, and such disclosure form shall not be construed to replace any provision of the policy itself.

(b) Every insurer and producer shall update disclosure forms periodically to reflect changes in major coverages and exclusions of such policies of insurance and changes in factors considered in cancellation, nonrenewal, and increase-in-premium situations.

(c) Every insurer and producer or his or her designated agent shall furnish the required disclosure form to applicants for insurance coverage at the time of the initial insurance purchase and thereafter on any renewal when there are changes in major coverages and exclusions or changes in factors considered in cancellation, nonrenewal, and increase-in-premium situations.

(d) An insurer or producer who violates this section shall be deemed to have engaged in unfair or deceptive acts or practices prohibited by section 10-3-1104 (1)(a)(I) and shall be subject to the penalties provided in sections 10-3-1108 and 10-3-1109.

(2) In addition to the disclosure required by subsection (1) of this section, any insurer or producer offering motor vehicle coverage pursuant to this part 6 shall provide a clear explanation to the insured regarding the products purchased, the amount of coverage purchased, and the applicability of the coverage depending on the determination of fault of the insured in an automobile accident.

(3) (a) An insurer or producer offering motor vehicle coverage pursuant to this part 6 shall not automatically add optional or enhanced coverages that will result in an increased premium to an insured's policy without the express consent of the insured. Such consent may be in the same medium in which the policy is offered. The insurer or producer, for three years, shall maintain adequate evidence of the insured's consent, and such evidence shall be subject to review by the commissioner. The insurer or producer shall record:

(I) Whether optional or enhanced coverage added for an increased premium to an insured's policy was requested by the insured or was recommended by the insurer or producer and consented to by the insured; and

(II) To the extent practicable, an explanation of why such coverage was changed.

(b) For the purposes of this section, "adequate evidence" means:

(I) Written notes or other memorializations of any oral or written communication with the insured kept within the normal course of business; or

(II) A declaration page indicating which coverages are not mandatory after payment of the premium is made unless the insured disputes such coverage within a reasonable time.

(c) This section shall not apply to changes in coverages mandated by law or to amended policy forms that are changed at renewal.

(4) The disclosure form required by subsection (1) of this section shall include a disclosure specifying that:

(a) Medical payments coverage pays for reasonable health-care expenses incurred for bodily injury caused by an automobile accident, regardless of fault, up to the policy limits chosen by the insured;

(b) Medical payments coverage is primary to any health insurance coverage available to an insured when injured in an automobile accident;

(c) Medical payments coverage applies to any coinsurance or deductible amount required to be paid by the person's health coverage plan, as defined in section 10-16-102 (34); and

(d) An insured who is injured in an automobile accident will not receive benefits from medical payments coverage for any medical expenses incurred as a result of an accident that is the fault of the insured unless medical payments coverage is purchased.

(5) The disclosure required by subsection (1) of this section shall include a disclosure of any coverages delivered or issued pursuant to section 10-4-610.

(6) (a) The commissioner may promulgate rules to address the suitability of coverages for insureds, including, but not limited to, administrative remedies against an insurer or producer for automatically adding optional or enhanced coverages that increase the insured's premium without the insured's consent, which additions may include, but are not limited to, remedies for violations of section 10-3-1104 (1)(j).

(b) The commissioner shall promulgate by rule a uniform disclosure form that reflects the requirements of this section. Such uniform disclosure form shall be used by insurers and producers in this state in order to comply with this section.

(7) Nothing in this section shall be construed to create a private right of action for damages by an insured.

(8) The disclosures required by this section shall not apply to commercial automobile insurance policies, as defined by the commissioner in rules adopted pursuant to section 10-4-641 (1).

Source: L. 2004: Entire section added, p. 455, § 1, effective July 1. **L. 2006:** Entire section amended, p. 38, § 4, effective January 1, 2007. **L. 2013:** (4)(c) amended, (HB 13-1266), ch. 217, p. 986, § 43, effective May 13.

10-4-637. No discrimination by profession. Reimbursement for lawfully performed health-care services covered by a policy providing medical payments coverage under a motor vehicle policy issued pursuant to this part 6 shall not be denied when such services are a covered benefit and rendered within the scope of practice for a licensed health-care provider; a massage therapist, as defined in section 12-235-104 (5); an occupational therapist, as defined in section 12-270-104 (9); or an occupational therapy assistant, as defined in section 12-270-104 (11), performing the services.

Source: L. 2004: Entire section added, p. 530, § 1, effective January 1, 2005. **L. 2007:** Entire section amended, p. 2019, § 9, effective June 1. **L. 2008:** Entire section amended, p. 830, § 6, effective July 1; entire section amended, p. 1994, § 4, effective July 1. **L. 2010:** Entire section amended, (HB 10-1220), ch. 197, p. 855, § 21, effective July 1. **L. 2019:** Entire section amended, (HB 19-1172), ch. 136, p. 1652, § 36, effective October 1. **L. 2021:** Entire section amended, (SB 21-003), ch. 4, p. 28, § 4, effective January 21.

Editor's note: Amendments to this section by Senate Bill 08-152 and Senate Bill 08-219 were harmonized.

10-4-638. Retroactive adjustment of health-care service claims. (1) Twelve months or more after the date a claim is paid for health-care services performed pursuant to this part 6, an insurer may not retroactively adjust the payment of the claim.

(2) Adjustments to claims made pursuant to a policy providing for medical payments coverage in cases where a carrier has reported fraud or abuse, pursuant to section 10-1-128 (5)(a)(IV), committed by the provider shall not be subject to the requirements of subsection (1) of this section.

Source: L. 2004: Entire section added, p. 530, § 1, effective January 1, 2005.

10-4-639. Claims practices for property damage. (1) An insurer shall pay title fees, sales tax, and any other transfer or registration fee associated with the total loss of a motor vehicle.

(2) An insurer shall clearly disclose to an insured or inform a third-party claimant what benefits are provided related to towing and storage of a motor vehicle that sustains property damage and shall specifically advise an insured or third-party claimant concerning excess charges that may be incurred related to towing and storage of a motor vehicle for which the insured or third-party claimant may be responsible.

(3) An insurer shall establish a fair and consistent method for determining total loss of a motor vehicle. Such method shall include consideration of unique characteristics of the motor vehicle and a credible source of valuation. An insurer shall maintain a record of its methodology for determining total loss evaluation and provide such methodology to the commissioner upon request. The commissioner may promulgate rules for the administration and enforcement of this subsection (3). An insurer may not use different credible sources of valuation only to determine the lowest amount payable for the total loss of the motor vehicle.

(4) The commissioner shall promulgate rules concerning when payments for any applicable replacement motor vehicle shall be made by an insurer and collision waivers for third-party claimant coverage.

Source: L. 2004: Entire section added, p. 895, § 4, effective May 21.

10-4-640. Operator's policy of insurance. (1) Except as otherwise provided in subsection (8) of this section, any natural person may satisfy the requirements of section 10-4-619 by obtaining, in lieu of an owner's policy of insurance, an operator's policy of liability insurance that meets the requirements of this section and of this part 6.

(2) An operator's policy of liability insurance shall provide coverage and shall state in a conspicuous type face and font on the face of the policy, that:

(a) The insurer is only liable under the policy for liability or damages incurred by the insured while the named insured is the operator of a motor vehicle or while a motor vehicle owned by the insured is not being operated by any other person;

(b) The policy does not provide coverage for any vicarious liability imposed on the owner of the motor vehicle as a result of the operation by another person of a motor vehicle owned by the insured;

(c) The coverage provided by the policy may not meet the requirements of the mandatory motor vehicle insurance or financial responsibility laws of another state.

(3) No operator's policy of liability insurance issued pursuant to this section may be delivered or issued for delivery in this state unless the insured has signed a statement, in the same medium as the application was taken, that appears on the contract and states that the insured has read and understood the policy and its limitations.

(4) An owner of a motor vehicle that is registered or required to be registered in this state and who holds an operator's policy of liability insurance shall not permit another person to operate such motor vehicle if the owner knows or should have known that the person does not have insurance to cover such other person's operation of such motor vehicle. If a motor vehicle insured under an operator's policy of liability insurance is driven by a person who does not have in effect a complying policy as required by section 10-4-619 and such person is involved in an accident, the owner of such motor vehicle and such driver shall be liable for any liability or damages arising out of such person's use of the motor vehicle.

(5) An operator's policy of liability insurance shall not provide coverage for damages incurred while a person other than the named insured is operating a motor vehicle.

(6) An operator's policy of liability insurance may provide coverage that applies in other jurisdictions if the coverage available pursuant to this section does not meet the mandatory motor vehicle insurance or financial responsibility requirements of other jurisdictions.

(7) An operator's policy of liability insurance shall provide coverage for liability incurred by the insured while a motor vehicle owned by the insured is not being operated by any other person.

(8) This section shall not apply to a lessor, dealer, manufacturer, rebuilder, or distributor of a motor vehicle; an owner of a fleet; a common, contract, or private motor carrier; or any other individual who owns a motor vehicle for use in the individual's business.

(9) If an insurer writing policies of insurance pursuant to this part 6 offers an operator's policy of insurance, such policy shall meet the requirements of this section.

Source: L. 2004: Entire section added, p. 895, § 4, effective May 21.

10-4-641. Rules - medical payments coverage. (1) The commissioner shall promulgate any necessary rules for the administration of medical payments coverage and coordination of benefits and the implementation of section 10-4-636 (4) concerning disclosures required to be made regarding medical payments coverage and the definition of commercial automobile insurance policies for purposes of the exception allowed in section 10-4-636 (8). Medical payments coverage shall be primary to any health insurance benefit of a person injured in a motor vehicle accident, and medical payments coverage shall apply to any coinsurance or deductible amount required by the injured person's health coverage plan, as defined in section 10-16-102 (34).

(2) Repealed.

Source: L. 2004: Entire section added, p. 1340, § 1, effective May 28. **L. 2005:** (2) repealed, p. 468, § 3, effective July 1; (1) amended, p. 468, § 2, effective January 1, 2006. **L. 2006:** (1) amended, p. 40, § 5, effective January 1, 2007. **L. 2013:** (1) amended, (HB 13-1266), ch. 217, p. 986, § 44, effective May 13.

10-4-642. Prompt payment of direct benefits - legislative declaration - definitions. (1) The general assembly finds, determines, and declares that patients and health-care providers are entitled to receive reimbursements from auto insurance entities in a timely manner. Therefore, it is in the interest of the citizens of Colorado that reasonable standards be imposed for the timely payment of claims.

(2) As used in this section, unless the context otherwise requires:

(a) "Claim" means a claim for payment of medical payments coverage benefits in accordance with the insurer's policy.

(b) "Claimant" means a policyholder, insured, or injured person entitled to medical payments benefits as a result of a motor vehicle accident or a provider with the proper assignment of benefits.

(c) "Clean claim" means:

(I) A claim where there is no additional information needed by the insurer to accept or deny the claim. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (6) of this section.

(II) A claim form that is submitted with, or after submission of, a properly executed application form for benefits currently used by the insurer by the policyholder, insured, or injured person entitled to benefits.

(3) The commissioner may, in consultation with interested parties, including health-care providers, adopt a uniform application form for medical payments benefits or a uniform claim form or both a uniform application and uniform claim form. For a uniform claim form or a uniform application form having elements provided by a health-care provider, the commissioner shall consider the uniform claim forms and elements adopted for health insurance pursuant to section 10-16-106.3. If the commissioner determines that new elements are required to establish that an injury or benefit requested is the result of a motor vehicle accident, the new elements may be listed in a separate uniform application form.

(4) (a) A claimant may submit a claim:

(I) By United States mail, first class, or by overnight delivery service;

(II) Electronically, if the insurer accepts claims electronically, to the location designated by the insurer;

(III) By facsimile to the location designated by the insurer; or

(IV) By hand delivery to the location designated by the insurer.

(b) (I) The provider may contact the insurer for the purpose of resubmission of a claim. The insurer shall have a separate facsimile process to receive resubmitted paper claims. A resubmitted claim shall be deemed received on the date of the facsimile transmission acknowledgment.

(II) If a claim is submitted electronically, it is presumed to have been received by the insurer or the insurer's clearinghouse, if applicable, on the date of the electronic verification of receipt. If a claim is submitted by facsimile, it is presumed to have been received by the insurer or the insurer's clearinghouse, if applicable, on the date of the facsimile transmission acknowledgment. If a claim is submitted by mail, it is presumed to have been received by the insurer or the insurer's clearinghouse, if applicable, three business days after the date of mailing. If a claim is submitted by overnight delivery service or by hand delivery, it is presumed to have been received on the date of delivery.

(c) The presumptions in paragraph (b) of this subsection (4) may be rebutted by:

(I) A date stamp on a claim showing the date of receipt. Such date shall be presumed the date of receipt.

(II) The fact that the insurer's records maintained in the ordinary course of business do not evidence receipt of a claim. In such case, the claim shall be deemed not to have been received by the insurer.

(d) An insurer shall maintain claim data that is accessible and retrievable for examination by the commissioner for the current year and for the two immediately preceding years. For each claim, an insurer shall provide a claim number, date of loss, date of auto accident, date of receipt of an application for benefits, date of receipt of a claim, date of payment of a claim, and date of denial or date the claim is closed without payment. An insurer shall detail all material activities relative to a claim. A claim file shall have all material documentation relative to a claim. Each material document within a claim file shall be noted as to date received, date processed, or date sent. Detailed documentation shall be contained in each claim file to permit reconstruction of the insurer's activities relative to each claim.

(5) (a) Every insurer shall provide a copy of its claim filing requirements to every insured or provider upon request within fifteen calendar days after the request is received by the insurer.

(b) Every insurer shall, within fifteen calendar days after receipt of a notification of loss, an application for benefits, or a claim, provide the necessary application or claim forms and instructions so that the claimant can comply with the policy conditions.

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

(b) If the resolution of a claim requires additional information, the insurer shall, within thirty calendar days after receipt of the claim, give to the claimant a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the insurer within thirty calendar days after receipt of such request. The insurer may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to the resubmittal of the claim or terms of the policy. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the insurer within thirty days after receipt of additional information or after the applicable time period set forth in paragraph (c) of this subsection (6).

(c) Absent fraud, all claims other than clean claims shall be paid, denied, or settled within ninety calendar days after receipt by the insurer; except that the commissioner may adopt rules for the purpose of exempting an insurer from the requirement that the insurer pay, deny, or settle a claim within ninety calendar days in circumstances where the investigation of a claim by the insurer is incomplete or otherwise needs to be continued and for extraordinary or unusual claims with extenuating circumstances as determined by the commissioner. The rules shall require the insurer, within thirty days after the receipt of a claim and every thirty days thereafter, to send to the claimant or the claimant's representative, and to the health-care provider if applicable, a letter setting forth the reasons why additional time is needed. The insurer that is exempt from the ninety-day time period due to circumstances where an investigation is incomplete or otherwise needs to be continued shall pay, deny, or settle the claim within one

hundred eighty days after receipt of the claim. An insurer that is exempt from the ninety-day time period shall not be exempt from payment of the interest due pursuant to subsection (7) of this section.

(d) No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial shall be in writing and given to the claimant, and the claim file shall contain documentation of the basis for the denial. The commissioner may adopt a rule regarding the time period for delivery of the denial to the claimant, which shall be the same or shorter time period than the period in which the claim was delivered.

(7) An insurer that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (6) of this section or fails to take other required action within the time periods set forth in paragraph (b) of subsection (6) of this section shall be liable for the covered benefit and, in addition, shall pay to the claimant interest at the rate of ten percent per annum for the first one hundred eighty days and at the rate of fifteen percent per annum thereafter, on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (6) of this section. Except for shorter time periods for clean claims, all interest begins to accrue ninety calendar days after receipt of the claim by the insurer.

(8) If an insurer delegates its claims processing functions to a third party, the delegation agreement shall provide that the claims processing entity shall comply with the requirements of this section. Any delegation by the insurer shall not be construed to limit the insurer's responsibility to comply with this section or any other applicable provision of this article.

(9) This section shall not apply to claims filed pursuant to the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S.

(10) The commissioner may investigate claims against an insurer that is authorized to conduct business in this state when such claims are filed by a provider related to the improper handling or denial of benefits pursuant to this section.

(11) The commissioner may impose, after proper notice and hearing, any other penalties set forth in this title against an insurer who has a pattern and practice of violations of this section.

(12) When an insured entitled to benefits under medical payments coverage is injured or believes that he or she has been injured in an accident and is examined or treated by a health-care provider, such health-care provider shall notify the insurer within thirty calendar days after the insured's initial visit. This subsection (12) shall not apply to a hospital or other health facility or entity licensed or certified pursuant to section 25-1.5-103 (1), C.R.S.

Source: L. 2004: Entire section added, p. 1098, § 1, effective July 1.

Editor's note: This section was originally numbered as § 10-4-634 in Senate Bill 04-125, but has been renumbered on revision for ease of location.

10-4-643. Electronic claim forms - rules. The commissioner may promulgate rules, consistent with section 10-4-642, for an insurer to accept claim forms for medical payments coverage benefits from health-care providers in electronic form. An insurer shall not prohibit the submission of a medical payments coverage benefit claim in hard-copy form, nor shall an insurer be prohibited from requiring that a claim be submitted in hard-copy form. An insurer shall not

require submission of a medical payments coverage benefit claim form other than those set forth in section 10-4-642.

Source: L. 2004: Entire section added, p. 1098, § 1, effective July 1.

Editor's note: This section was originally numbered as § 10-4-635 in Senate Bill 04-125, but has been renumbered on revision for ease of location.

10-4-644. Child restraint system - insurance coverage - definition. [*Editor's note: This section is effective January 1, 2026.*]

(1) (a) An insurer that issues or renews a policy pursuant to this part 6 shall include in the applicable coverage the replacement cost of a child restraint system that is in a motor vehicle at the time of a motor vehicle accident, and to which the coverage in the policy is applicable.

(b) Upon the submission of a claim to an insurer for a loss resulting from a motor vehicle accident, the insurer shall ask the claimant if a child restraint system was in the motor vehicle at the time that the accident occurred and, if so, the applicable policy covering the motor vehicle accident shall pay the cost to replace the child restraint system or reimburse the claimant for the cost of the replacement of the child restraint system.

(2) As used in this section, "child restraint system" has the meaning set forth in section 42-4-236 (1)(a.5).

Source: L. 2025: Entire section added, (HB 25-1179), ch. 80, p. 336, § 1, effective January 1, 2026.

Editor's note: Section 2(2) of chapter 80 (HB 25-1179), Session Laws of Colorado 2025, provides that the act adding this section applies to automobile insurance policies issued or renewed and insurance claims filed on or after January 1, 2026.

PART 7

MOTOR VEHICLE ("NO-FAULT") INSURANCE

10-4-701 to 10-4-726. (Repealed)

Editor's note: (1) This part 7 was numbered as article 25 of chapter 13, C.R.S. 1963. For amendments to this part 7 prior to its repeal in 2003, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

(2) Section 10-4-726 provided for the repeal of this part 7, effective July 1, 2003. (See L. 2002, p. 649.)

PART 8

MEDICAL LIABILITY EXTRAORDINARY LOSS FUND

10-4-801 to 10-4-808. (Repealed)

Source: L. 91: Entire part repealed, p. 1166, § 1, effective April 11.

Editor's note: This part 8 was added in 1976 and was not amended prior to its repeal in 1991. For the text of this part 8 prior to its repeal in 1991, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

PART 9

MEDICAL MALPRACTICE INSURANCE - JOINT UNDERWRITING ASSOCIATION

10-4-901 to 10-4-913. (Repealed)

Source: L. 2010: Entire part repealed, (HB 10-1220), ch. 197, p. 853, § 12, effective July 1.

Editor's note: This part 9 was added in 1976. For amendments to this part 9 prior to its repeal in 2010, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

PART 10

FRAUDULENT CLAIMS AND ARSON INFORMATION REPORTING ACT

Cross references: For penalty provisions for arson, see part 1 of article 4 of title 18.

10-4-1001. Short title. This part 10 shall be known and may be cited as the "Fraudulent Claims and Arson Information Reporting Act".

Source: L. 79: Entire part added, p. 390, § 1, effective June 7. **L. 93:** Entire part amended, p. 393, § 3, effective July 1.

10-4-1002. Definitions. As used in this part 10, unless the context otherwise requires:

(1) "Authorized agency" means:

(a) A fire department;

(b) The Colorado bureau of investigation, the office of the attorney general, and any other law enforcement agency authorized or charged with the investigation of crimes;

(c) Any district attorney or county attorney and their representatives; and

(d) Any professional licensing board or regulatory agency, including, without limitation, the division of insurance.

(1.5) "Fraudulent insurance act" has the meaning set forth in section 10-1-128 or means the commission of insurance fraud pursuant to section 18-5-211, C.R.S.

(2) "Insurer" means any insurer and any person licensed or regulated under this title and Pinnacol Assurance.

(3) "Notice" or "notify" means the notification in writing to an authorized agency by an insurer.

(4) "Person" means every natural person, firm, partnership, association, or corporation.

(5) "Relevant" means information having any tendency to make the existence of any fact that is of consequence to the investigation or determination of the issue more probable or less probable than it would be without the evidence.

(6) "Secondary agency" means any for-profit or nonprofit organization funded directly or indirectly by insurers that engages in the gathering and dissemination of information concerning insurance fraud and that has an established process in place to affirmatively forward information to an authorized agency for further investigation and prosecution. The commissioner, by rule, shall designate which organizations are secondary agencies.

Source: L. 79: Entire part added, p. 390, § 1, effective June 7. **L. 93:** Entire part amended, p. 393, § 3, effective July 1. **L. 2000:** (1) amended and (1.5) added, p. 1734, § 1, effective June 1. **L. 2002:** (2) amended, p. 1891, § 49, effective July 1. **L. 2003:** (1.5) amended, p. 617, § 13, effective July 1. **L. 2013:** (6) added, (HB 13-1262), ch. 310, p. 1638, § 1, effective August 7. **L. 2014:** (1.5) amended, (SB 14-092), ch. 190, p. 710, § 3, effective July 1.

10-4-1003. Disclosure of information. (1) (a) When any person or insurer has reason to believe that a fire loss may have been caused by other than accidental means or that any insurance claim may be fraudulent, then such person may, and such insurer shall, notify an authorized agency or a secondary agency.

(b) A notification pursuant to paragraph (a) of this subsection (1) shall be confidential, shall not constitute a public record under part 2 of article 72 of title 24, C.R.S., and shall not be discoverable or admissible in any civil action.

(c) No insurer, authorized agency, or secondary agency shall intentionally refuse to release any relevant information concerning a possible nonaccidental fire loss or fraudulent insurance act, upon request, to:

(I) An insurer that is or could be required to pay a claim to which such information relates; or

(II) Any authorized agency.

(2) Any authorized agency may, in writing, require the insurer having an interest in a fire loss or other claim to release to the authorized agency specific, relevant information or evidence deemed important by the authorized agency which the insurer has in its possession and which relates to the fire loss or other claim in question. Relevant information may include, but shall not be limited to:

(a) Insurance policy information pertaining to a fire loss or other claim under investigation and any application for such a policy;

(b) Policy premium payment records;

(c) History of previous claims made by the insured; and

(d) Any other material relating to the investigation of the loss, including statements of any person who may have information about the loss and any proof of such loss.

(3) Nothing in subsection (1) of this section shall abrogate or impair the rights or powers created under subsection (2) of this section.

(4) Any authorized agency or secondary agency provided with relevant information or evidence pursuant to subsection (1) or (2) of this section may release such information to any other authorized agency, insurer, or secondary agency.

(5) Any insurer providing information to an authorized or secondary agency or agencies pursuant to subsection (1) or (2) of this section may, in writing, request such agency to release to such insurer specific, relevant information or evidence relating to the fire loss or other claim under investigation. Such agency may, in its sole discretion, and with such restrictions as such agency deems appropriate, release such information to such insurer.

(6) Any authorized agency or secondary agency receiving a notice or other information pursuant to this part 10 may release such notice or other information to other authorized agencies, insurers, or secondary agencies.

(7) Any insurer providing information pursuant to subsection (1) or (2) of this section shall cooperate with any law enforcement agency of competent jurisdiction.

(8) (a) Any person that has reason to believe that a fire loss may have been caused by other than accidental means, that any insurance claim or application for insurance coverage may be fraudulent, or that a fraudulent insurance act has been committed, may, and any insurer that has reason to believe the same shall, furnish and disclose any relevant information in its possession concerning such loss, claim, or act to any insurer or authorized agency for the purpose of detecting, prosecuting, or preventing fraudulent insurance claims. Such reporting shall be confidential, shall not be a public record under article 72 of title 24, C.R.S., and shall not be discoverable or admissible under the Colorado rules of civil procedure in any civil litigation, but only to the extent that the insurer or person disclosing the information is granted immunity under section 10-4-1005. The immunity as set forth in section 10-4-1005 shall apply to any report made pursuant to this subsection (8). The commissioner of insurance may promulgate rules regarding such reporting.

(b) Paragraph (a) of this subsection (8) shall not be construed to prohibit the admission of evidence of a fraudulent insurance act:

(I) In any civil litigation involving such fraudulent insurance act; or

(II) In any civil litigation involving the alleged disclosure of information as to which the insurer or person alleged to have made such disclosure does not have immunity under section 10-4-1005.

(c) An insurer disclosing information to another insurer under this subsection (8) may make a written request to such other insurer for the release of information relating to other fire losses, insurance claims, or applications for coverage submitted by the same insured or applicant; except that such request and any such release of information shall be solely for the purpose of detecting, investigating, preventing, or prosecuting an actual or suspected fraudulent insurance act. Information so provided shall not be used for underwriting or rating purposes except in connection with an application or policy under which a fraudulent insurance act was committed. Information released pursuant to such request shall be subject to the confidentiality and immunity provisions of paragraph (a) of this subsection (8).

Source: L. 79: Entire part added, p. 391, § 1, effective June 7. **L. 93:** Entire part amended, p. 394, § 3, effective July 1. **L. 94:** (1) amended, p. 328, § 2, effective July 1. **L. 96:** (8) added, p. 289, § 4, effective July 1. **L. 2000:** (1) and (8) amended, p. 1734, § 2, effective June 1. **L. 2013:** (1)(a), IP(1)(c), (4), (5), and (6) amended, (HB 13-1262), ch. 310, p. 1638, § 2, effective August 7.

10-4-1004. Evidence - confidential. (1) Any authorized agency, secondary agency, or insurer which receives any information furnished pursuant to this part 10 shall hold the information in confidence except as provided in section 10-4-1003 (4) or until such time as its release is required pursuant to a civil or criminal proceeding.

(2) Any authorized agency or its agents or employees may be required to testify in any civil or criminal proceeding in which the insurer at interest is named as a party.

Source: L. 79: Entire part added, p. 391, § 1, effective June 7. **L. 93:** Entire part amended, p. 395, § 3, effective July 1. **L. 2013:** (1) amended, (HB 13-1262), ch. 310, p. 1639, § 3, effective August 7.

10-4-1005. Immunity. (1) In the case of actions taken under this part 10, and except where information is furnished with knowledge that the information is false or with reckless disregard for its truth or falsity, there may be no civil penalty or damages on the part of, and no claim for relief may be brought against, any person, insurer, or authorized agency or secondary agency for furnishing information or taking other action pursuant to the provisions of this part 10.

(2) Every person, insurer, and authorized agency and secondary agency is immune from civil liability when acting in good faith to cooperate with, furnish evidence to or on behalf of, provide information to, or solicit or receive information from, any of the following with regard to an actual or suspected fraudulent insurance act:

(a) An agency of the federal or any state, county, or municipal government that is involved in the detection, prosecution, or prevention of arson or insurance fraud;

(a.5) Any secondary agency;

(b) Any employee or agent of an agency listed in subsection (2)(a) or (2)(a.5) of this section; and

(c) Another insurer, if acting in accordance with section 10-4-1003 (8)(c) solely for the purpose of detecting, investigating, preventing, or prosecuting an actual or suspected fraudulent insurance act. Information so provided may not be used for underwriting or rating purposes except in connection with an application or policy under which a fraudulent insurance act was committed.

(3) Every person, insurer, and authorized agency and secondary agency is immune from civil liability when acting in good faith to comply with a court order to provide evidence or testimony with regard to an actual or suspected fraudulent insurance act; except that such immunity does not apply to a person or insurer that has committed, or has conspired in or aided and abetted the commission of, such fraudulent insurance act.

(4) The immunity granted by this section shall be in addition to, and not in lieu of, any right, privilege, or immunity available under the common law or any other applicable statute or rule.

Source: L. 79: Entire part added, p. 391, § 1, effective June 7. **L. 93:** Entire part amended, p. 395, § 3, effective July 1. **L. 94:** Entire section R&RE, p. 328, § 3, effective July 1. **L. 2000:** Entire section amended, p. 1736, § 3, effective June 1. **L. 2017:** (1), (2), and (3) amended, (HB 17-1048), ch. 68, p. 215, § 3, effective August 9.

10-4-1006. Enforcement. (1) No person, authorized agency, or insurer shall:

(a) Intentionally or knowingly refuse to release any information requested pursuant to section 10-4-1003 (2);

(b) Intentionally or knowingly fail to provide authorized agencies with relevant information pursuant to section 10-4-1003 (1); or

(c) Fail to hold in confidence information required to be held in confidence pursuant to section 10-4-1004 (1).

Source: L. 79: Entire part added, p. 391, § 1, effective June 7. **L. 93:** Entire part amended, p. 395, § 3, effective July 1.

10-4-1007. Penalty. Any person who violates any of the provisions of this part 10 commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.

Source: L. 79: Entire part added, p. 392, § 1, effective June 7. **L. 93:** Entire part amended, p. 396, § 3, effective July 1. **L. 2002:** Entire section amended, p. 1468, § 26, effective October 1.

Cross references: For the legislative declaration contained in the 2002 act amending this section, see section 1 of chapter 318, Session Laws of Colorado 2002.

10-4-1008. Municipal ordinances - concurrent jurisdiction - common law. (1) The provisions of this part 10 shall not be construed to affect, supersede, or repeal any ordinance of any municipality relating to fire prevention or control of arson.

(2) The Colorado bureau of investigation shall have investigative authority concurrent with that of county or municipal authorities when the county or municipality in which investigation of a fire loss or other claim is taking place requests the assistance of said bureau.

(3) With the exception of section 10-4-1005, the provisions of this part 10 shall not be construed to impair any existing statutory or common law rights, immunities, privileges, or powers.

Source: L. 79: Entire part added, p. 392, § 1, effective June 7. **L. 93:** Entire part amended, p. 396, § 3, effective July 1.

10-4-1009. Continuing duties of insurers - unfair claim settlement practices. The provisions of this part 10 shall not be construed to affect or supersede the duties of insurers and other persons pursuant to the provisions of part 11 of article 3 of this title.

Source: L. 93: Entire part amended, p. 396, § 3, effective July 1.

PART 11

COMMERCIAL LIABILITY INSURANCE JOINT UNDERWRITING ASSOCIATION

10-4-1101 to 10-4-1114. (Repealed)

Source: L. 2010: Entire part repealed, (HB 10-1220), ch. 197, p. 853, § 13, effective July 1.

Editor's note: This part 11 was added in 1987. For amendments to this part 11 prior to its repeal in 2010, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

PART 12

TRANSACTION OF BUSINESS WITH PRODUCER-CONTROLLED PROPERTY AND CASUALTY INSURERS

10-4-1201. Definitions. As used in this part 12, unless the context otherwise requires:

(1) "Accredited state" means a state in which the insurance department has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the national association of insurance commissioners ("NAIC").

(2) "Control" or "controlled" has the meaning set forth in section 10-3-801 (3).

(3) "Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

(4) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

(5) "Insurance department" means the commissioner or other government official or agency of a state other than Colorado exercising powers and duties substantially equivalent to those of the commissioner or the division.

(6) "Insurer" or "licensed insurer" means any person, firm, association, or corporation duly licensed to transact a property and casualty insurance business in this state. The following are not licensed insurers for the purposes of this part 12, and this list is not exclusive:

(a) All risk retention groups as defined in the "Superfund Amendments and Reauthorization Act of 1986", Pub.L. 99-499, 100 Stat. 1613 (1986), the "Liability Risk Retention Act of 1986", 15 U.S.C. sec. 3901 et seq., and the "Model Risk Retention Act", part 14 of article 3 of this title;

(b) All residual market pools and joint underwriting authorities or associations; and

(c) All captive insurers. For the purposes of this part 12, "captive insurers" are insurance companies owned by another organization and whose exclusive purpose is to insure risks of the parent organization and affiliated companies, or, in the case of groups and associations, captive insurers are insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations, or to group members and their affiliates, or to both.

(7) "Producer" means an insurance broker or brokers or any other person, firm, association, or corporation when, for any compensation, commission, or other thing of value, such person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than the said person, firm, association, or corporation.

Source: L. 92: Entire part added, p. 1486, § 19, effective July 1. **L. 2020:** (6)(a) amended, (HB 20-1402), ch. 216, p. 1042, § 13, effective June 30.

10-4-1202. Minimum standards. (1) **Applicability of section.** (a) The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent of the admitted assets of the controlled insurer, as reported in the controlled insurer's annual statement filed as of December 31 of the prior year.

(b) Notwithstanding paragraph (a) of this subsection (1), the provisions of this section shall not apply if:

(I) The controlling producer:

(A) Places insurance only with the controlled insurer or only with the controlled insurer and a member or members of the controlled insurer's holding company system or with the controlled insurer's parent, affiliate, or subsidiary and receives no compensation in connection with such insurance; and

(B) Accepts insurance placements only from nonaffiliated subproducers, and not directly from insureds;

(II) The controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

(2) A controlled insurer shall not accept business from a controlling producer, and a controlling producer shall not place business with a controlled insurer, unless there is a written contract between the controlling producer and the controlled insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the controlled insurer and contains the following minimum provisions:

(a) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer; and the controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination;

(b) The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the controlling producer;

(c) The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis; and the due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than ninety days after the effective date of any policy placed with the controlled insurer under this contract;

(d) All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the federal reserve system, in accordance with the

provisions of the insurance law as applicable; and funds of a controlling producer not required to be licensed in this state shall be maintained in compliance with the requirements of the controlling producer's domiciliary state;

(e) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer; and such records shall be retained for a period of five years commencing no later than the effective date of the last financial examination of the insurer;

(f) The contract shall not be assigned in whole or in part by the controlling producer;

(g) The controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks, which standards, rules, procedures, rates, and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer and to which standards, rules, procedures, rates, and conditions the controlling producer shall adhere;

(h) The rates and terms of the controlling producer's commissions, charges, or other fees and a definition of the purposes for those charges; and the rates of the commissions, charges, and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this paragraph (h) and paragraph (g) of this subsection (2), examples of "comparable business" include, without limitation, the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

(i) If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least five years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to paragraph (a) of subsection (4) of this section.

(j) A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings, which limit may be different for each line or sub-line of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached.

(k) The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer; except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(3) **Audit committee.** Every controlled insurer shall have an audit committee of the board of directors, which committee shall be composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

(4) **Reporting requirements.** (a) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the commissioner an opinion of an independent casualty actuary or such other independent loss reserve specialist acceptable to the commissioner reporting loss ratios for each line of business written and certifying to the adequacy of loss reserves established for losses incurred and outstanding as of year-end including incurred but not reported reserves on business placed by the producer.

(b) The controlled insurer shall annually report to the commissioner the amount of commissions paid to the producer, the percentage such amount represents of the net premiums written, and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

Source: L. 92: Entire part added, p. 1487, § 19, effective July 1.

10-4-1203. Disclosure. The producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer; except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain, as part of the controlling producer's records, a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has notified or will notify the insured.

Source: L. 92: Entire part added, p. 1490, § 19, effective July 1.

10-4-1204. Penalties. (1) (a) If the commissioner believes that the controlling producer or any other person has not materially complied with this part 12 or with any regulation or order promulgated pursuant thereto, after notice and opportunity to be heard, the commissioner may order the controlling producer to cease placing business with the controlled insurer.

(b) If it was found that, because of such material noncompliance, the controlled insurer or any policyholder thereof has suffered any loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or for other appropriate relief.

(2) If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to part 5 of article 3 of this title, and the receiver appointed under such order believes that the controlling producer or any other person has not materially complied with this part 12 or with any regulation or order promulgated pursuant thereto and that, as a result, the insurer suffered any loss or damage, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(3) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the laws of this state governing insurance.

(4) Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors, or other third parties.

Source: L. 92: Entire part added, p. 1490, § 19, effective July 1.

10-4-1205. Applicability. This part 12 shall apply to licensed insurers as defined in section 10-4-1201 (6), whether domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of part 8 of article 3 of this title, to the extent they are consistent with the provisions of this part 12, shall continue to apply to all parties within holding company systems subject to this title.

Source: L. 92: Entire part added, p. 1491, § 19, effective July 1.

10-4-1206. Effective date. This part 12 shall take effect July 1, 1992. Controlled insurers and controlling producers who are not in compliance with section 10-4-1202 as of such date shall have sixty days thereafter to come into compliance with said section and shall, in addition, comply with section 10-4-1203 beginning with all policies written or renewed on or after the sixty-first day after the said date.

Source: L. 92: Entire part added, p. 1491, § 19, effective July 1.

PART 13

BLACK LUNG DISEASE INSURANCE JOINT UNDERWRITING ASSOCIATION

10-4-1301. Legislative declaration. The purpose of this part 13 is to ensure the continuing availability of necessary black lung insurance in this state by establishing a temporary market for black lung insurance coverage. It is intended that the nonprofit temporary joint underwriting association created by this part 13 operate on a self-supporting basis, without subsidy from its members, to make the necessary black lung insurance available for an interim period in order to allow the voluntary market to respond or to provide additional time to the general assembly to consider appropriate remedial legislation addressing the problems of availability and high cost of black lung insurance.

Source: L. 95: Entire part added, p. 731, § 1, effective May 23.

10-4-1302. Definitions. As used in this part 13, unless the context otherwise requires:

(1) "Association" means the joint underwriting association created pursuant to this part 13.

(2) "Black lung insurance" means any insurance policy providing coverage to employers subject to the "Federal Coal Mine Health and Safety Act of 1969", 30 U.S.C. secs. 931 to 942, as amended.

(3) "Board" means the board of directors of the association.

Source: L. 95: Entire part added, p. 731, § 1, effective May 23.

10-4-1303. Temporary joint underwriting association. (1) A nonprofit temporary joint underwriting association is hereby created, consisting of all insurance carriers authorized to transact business in this state, including Pinnacol Assurance, that insures employers against

liability for compensation under the provisions of articles 40 to 47 of title 8, C.R.S., who shall constitute the members thereof. Every such insurer shall participate in the association as a condition of its authority to continue to make contracts of such kind of insurance in this state.

(2) The purpose of the association shall be to provide black lung insurance coverage for employers located in Colorado who are in good faith entitled to such coverage but who are unable to purchase such insurance through the voluntary market.

(3) The association shall issue policies beginning immediately; except that the association shall not commence underwriting operations until the commissioner finds that black lung insurance is not, or as of a determinable date will not be, available or cannot be made available in the voluntary market or the cost is so unreasonably high as to make such insurance practicably unavailable.

(4) (a) The association shall, pursuant to the provisions of this part 13 and the plan of operation, have the power on behalf of its members:

(I) To issue, or cause to be issued, policies of black lung insurance;

(II) To underwrite such insurance;

(III) To adjust and pay losses with respect thereto; and

(IV) To provide or cede reinsurance.

(b) The association may contract with one or more servicing carriers or any other appropriate entity to perform any or all of the duties of the association.

Source: L. 95: Entire part added, p. 732, § 1, effective May 23. **L. 2002:** (1) amended, p. 1891, § 50, effective July 1.

10-4-1304. Board of directors - authority. (1) The association shall be governed by a board of six directors, to be appointed by the commissioner. Such directors shall be individuals employed full-time in the business of writing workers' compensation insurance in Colorado, at least one shall be employed by Pinnacol Assurance, at least one shall be actively engaged in operations in a small underground mine, and at least one shall be actively engaged in operations in a large underground mine. The board shall elect a chairperson from among its members.

(2) The board shall have the authority to take all lawful actions necessary to implement this part 13, including, but not limited to, issuing policies as named insurer.

Source: L. 95: Entire part added, p. 732, § 1, effective May 23. **L. 2002:** (1) amended, p. 1891, § 51, effective July 1.

10-4-1305. Plan of operation - annual certification. (1) (a) The board shall submit to the commissioner a proposed plan of operation consistent with the provisions of this part 13. If the board fails to do so, the commissioner shall promulgate a plan of operation or part thereof, as the case may be. The plan of operation approved or promulgated by the commissioner shall become effective and operational upon order of the commissioner.

(b) The board may change the plan of operation at any time upon the board's initiative. Adoption of the plan and any changes thereto shall require the consent of two-thirds of the members and the approval of the commissioner.

(2) The plan of operation shall provide for the prompt and efficient provision of black lung insurance and shall contain other provisions including, but not limited to:

(a) A preliminary uniform assessment of all members, based on market share as measured by workers' compensation premium in this state, for initial expenses necessary to commence operations;

(b) The establishment of necessary facilities;

(c) The management of the association;

(d) A pro rata assessment of members to defray losses and expenses;

(e) Reasonable and objective underwriting standards;

(f) The cession of reinsurance;

(g) Appointments of servicing carriers or other servicing arrangements, including contracts with data service organizations; except that the criteria for selecting service providers shall include, at a minimum, experience in administration of workers' compensation with particular emphasis on workers' compensation residual market mechanisms;

(h) Procedures for determining amounts of insurance to be provided by the association;

(i) Criteria for eligibility for coverage under the plan;

(j) Programs to encourage insurers to provide black lung insurance coverage in the voluntary market;

(k) Procedures for publication of renewal dates of employers insured under the plan;

(l) Procedures for equitable distribution of applicants to the plan;

(m) The provision of policy, claims, and loss control services to the employers insured under the plan;

(n) Review of applications for coverage with the plan;

(o) Procedures for auditing employers insured under the plan, which procedures shall be based on reasonable business judgment and designed to maximize the likelihood that the plan will collect the appropriate premiums;

(p) Servicing carrier standards, commission schedules, and other provisions relating to agents who submit business to the plan;

(q) Termination of coverage of and refusal of future coverage to an insured employer that:

(I) Fails to make payments when due;

(II) Is delinquent in payment of workers' compensation or employers' liability insurance payments or deductible payments owed to a service provider or former insurer;

(III) Fails to comply with any reasonable loss control programs recommended by the plan; or

(IV) Fails to cooperate with reasonable investigation of claims involving its employees, payroll audits, or development of loss control recommendations.

(3) The plan shall use actuarially sound rates. The plan shall also put in place rates and rating plans for new applicants that had previously been self-insured. The plan may offer rating, dividend plans, and other means to encourage employers to participate in loss prevention programs. Rates and rating plans shall be subject to approval by the commissioner using the standards set forth in part 4 of this article.

Source: L. 95: Entire part added, p. 733, § 1, effective May 23.

10-4-1306. Deficits - assessment - rebate of surplus. (1) Whenever a deficit exists, the board shall, within ninety days, provide the commissioner with a program to eliminate the deficit within a reasonable time.

(2) Any premiums or assessments collected by the plan in excess of the amount necessary to fund projected ultimate incurred losses and expenses of the plan and not paid to insureds in conjunction with dividend programs shall be retained by the plan for future use as necessary to ensure the continued operational viability of the plan.

(3) If the plan incurs a deficit or surplus from operations in excess of the amount required under subsection (2) of this section, as determined by the commissioner, the amount of the deficit or surplus shall be assessed or rebated to the participating insurers. Each such insurer shall pay a portion of the total assessment or receive a portion of the total rebate based on its proportion of the total voluntary Colorado workers' compensation insurance written during the calendar year in which the deficit or surplus occurs.

Source: L. 95: Entire part added, p. 734, § 1, effective May 23.

10-4-1307. Annual statements. The association shall file in the office of the commissioner annually, on or before June 1, a statement which shall contain information with respect to its transactions, condition, operations, and affairs during the preceding year. Such statement shall contain an independent actuarial certification of the results of the operation of the plan and such other matters and information as are prescribed. The commissioner may prescribe the form of such statement and may, at any time, require the association to furnish additional information with respect to its transactions, condition, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation, and experience of the association.

Source: L. 95: Entire part added, p. 735, § 1, effective May 23.

10-4-1308. Examinations. (1) The commissioner shall make an examination into the affairs of the association at least annually.

(2) The evaluation shall include information on the administrative costs of operating a free-standing residual market mechanism as well as the need for rate adjustments necessary to make such mechanism entirely self-sustaining.

Source: L. 95: Entire part added, p. 735, § 1, effective May 23. **L. 97:** (2) amended, p. 1478, § 23, effective June 3.

10-4-1309. Legislative declaration - authority of commissioner - emergency rules - judicial review. (1) The general assembly finds, determines, and declares that the matters addressed in this part 13 are of the utmost urgency. Accordingly, the commissioner is authorized to, and shall, adopt emergency rules implementing this part 13 immediately. In addition, the commissioner is empowered to issue all necessary orders to implement this part 13 as soon as is practicable.

(2) To cover the commissioner's startup costs, the commissioner may assess insurers participating in the association based on each insurer's proportion of the total voluntary Colorado workers' compensation insurance written during calendar year 1994.

(3) All orders of the commissioner made pursuant to this part 13 shall be subject to judicial review by the court of appeals as provided in section 24-4-106 (11), C.R.S.; except that, notwithstanding any other provision of law, proceedings for review shall act as a stay of the enforcement of any order or decision of the insurance commissioner disapproving or ordering the withdrawal, adjustment, or termination of the effectiveness of any rate filing made by or on behalf of the association on the ground that the rates or premiums for the business of the association are unreasonable or excessive, and the association may continue to charge rates pursuant to such filing pending final order of the court.

Source: L. 95: Entire part added, p. 735, § 1, effective May 23.

10-4-1310. Privileged communications. There shall be no liability on the part of, and no civil suit for damages shall arise against, the association, the commissioner or his or her authorized representatives, or any other person or organization for any act or statement made in good faith by them during any proceedings or concerning any matters within the scope of this part 13.

Source: L. 95: Entire part added, p. 736, § 1, effective May 23.

10-4-1311. Tax exemption. The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real or personal property.

Source: L. 95: Entire part added, p. 736, § 1, effective May 23.

PART 14

EXEMPTION FROM RATE AND APPROVAL REQUIREMENTS FOR INSURERS PROVIDING COVERAGE TO EXEMPT COMMERCIAL POLICYHOLDERS

10-4-1401. Legislative declaration. The general assembly declares that the health, welfare, and safety of the people of the state of Colorado may not be enhanced by the regulation of insurance between sophisticated commercial entities and insurers. The general assembly finds that there are commercial entities that utilize personnel trained in risk management, insurance coverage issues, and insurance industry knowledge who are capable of negotiating and entering into insurance coverage agreements without the need for state regulation in this area. Therefore, the purpose of this part 14 is to exempt insurers negotiating with and insuring sophisticated commercial entities from rate filing and form certification requirements. This exemption will allow competitive underwriting and rating of policies.

Source: L. 99: Entire part added, p. 384, § 1, effective January 15, 2000.

10-4-1402. Rules. (1) (a) The commissioner shall promulgate rules necessary for the implementation and administration of this article. Such rules shall include, without limitation, the definition of what organizations and entities qualify as exempt commercial policyholders. Such definition shall require such organizations to be those purchasing type II kinds of insurance as specified in section 10-4-401 (3)(b), except the commissioner shall not include purchasers of title insurance within the definition of an exempt commercial policyholder. For purposes of promulgating such rules, the commissioner shall consider recommendations from risk management professionals, insurer representatives, producers, buyers, qualified insurance consultants, consumers of insurance products, and any other persons as necessary.

(b) (I) For the purposes of promulgating the definition of an exempt commercial policyholder, the commissioner shall mandate that an exempt commercial policyholder procure its insurance through use of a risk manager employed or retained by the exempt commercial policyholder. The qualifications of the risk manager shall be defined by the division of insurance pursuant to this section.

(II) The commissioner shall define all other criteria of an exempt commercial policyholder which criteria shall include but are not limited to the following, and each exempt commercial policyholder shall meet at least one of such criteria:

(A) The minimum amount for aggregate insurance premium sales for the exempt commercial policyholder;

(B) The minimum net worth of the exempt commercial policyholder;

(C) The minimum dollar amount for annual net revenues or sales for the exempt commercial policyholder;

(D) The minimum number of employees of the exempt commercial policyholder per individual insured, or, if the exempt commercial policyholder is a member of an affiliated group, the minimum number of employees in the employing group;

(E) A not-for-profit or public entity's minimum annual budget or assets; or

(F) A municipality's minimum population.

(2) The definition of an exempt commercial policyholder shall be reviewed periodically by the commissioner with the recommendations from risk management professionals, insurer representatives, producers, buyers, qualified insurance consultants, consumers of insurance products, and any other person as the commissioner deems necessary.

(3) The commissioner shall promulgate rules that define the disclosure requirements for insurance policies issued to exempt commercial policyholders. Each insurance policy issued to an exempt commercial policyholder shall contain a conspicuous disclaimer printed in at least ten-point, bold-faced type that states that the policy is exempt from the rate filing and approval and the form filing and certification requirements of the division of insurance.

(4) The division shall determine by rule the type of data, documents, reports, rate and form information, and any other information the commissioner determines necessary, to be collected from an insurer providing coverage to an exempt commercial policyholder when the division has received a complaint that an insurer is anticompetitive or not adequately servicing the needs of the exempt commercial policyholder.

(5) Rules promulgated under this section shall be promulgated in accordance with article 4 of title 24, C.R.S., and initially completed by January 15, 2000.

Source: L. 99: Entire part added, p. 384, § 1, effective January 15, 2000.

10-4-1403. Exemption from rate filing, approval, and form certification requirements. (1) The requirements of sections 10-4-107, 10-4-108, 10-4-109, 10-4-109.5, 10-4-109.7, 10-4-110, 10-4-113, 10-4-403, 10-4-404, 10-4-404.5, 10-4-414, 10-4-419, and 10-4-421 shall not apply to insurers of exempt commercial policyholders.

(2) If the commissioner determines, after providing an opportunity for comment and a public hearing, that a line of insurance is anticompetitive, as described in section 10-4-415, or is not being adequately serviced by insurers, the commissioner may require that the rate for that particular line of insurance be filed pursuant to section 10-4-401 and enforced under section 10-4-418.

(3) The commissioner shall review annually any line of insurance found previously to be anticompetitive, as described in section 10-4-415, to determine whether rate filing and approval requirements may again be eliminated because the line has subsequently become competitive. Such review shall include the opportunity for comment and a public hearing.

Source: L. 99: Entire part added, p. 386, § 1, effective January 15, 2000.

10-4-1404. Multistate insurance risks - choice of law. Where the exempt commercial policyholder operates in more than one state, the policy may include provisions within the insurance contract that determine disputes arising from claims handling and procedures, cancellation of the policy, or nonrenewal of the policy, which disputes shall be governed by the state with the largest percentage of premiums charged under the policy.

Source: L. 99: Entire part added, p. 386, § 1, effective January 15, 2000.

PART 15

PORTABLE ELECTRONICS INSURANCE

10-4-1501. Definitions. As used in this part 15, unless the context otherwise requires:

(1) "Customer" means a person who purchases portable electronics or services.

(2) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(3) "Insurer" means any admitted company or authorized company, as defined in section 10-1-102 (3), approved to transact insurance in this state.

(4) "Location" means any physical location in this state or any website, call center site, or similar location directed to residents of this state.

(5) "Portable electronics" means personal, self-contained, easily carried by an individual, battery-operated electronic communication, viewing, listening, recording, gaming, computing, or global positioning devices, including cell or satellite phones, pagers, personal global positioning satellite units, portable computers, portable audio listening, wireless devices, video viewing or recording devices, digital cameras, video camcorders, portable gaming systems, docking stations, automatic answering devices, and other similar devices and their accessories, and service related to the use of such devices.

(6) (a) "Portable electronics insurance" means insurance that provides coverage for the repair or replacement of portable electronics that may provide coverage for portable electronics against any one or more of the following causes of loss:

(I) Loss;

(II) Theft;

(III) Inoperability due to mechanical failure or malfunction;

(IV) Damage; or

(V) Other similar causes of loss.

(b) "Portable electronics insurance" does not include:

(I) A service contract governed by part 16 of this article;

(II) A service contract that is in effect as of January 1, 2013, that provides coverage for the loss of portable electronics associated with an ongoing service relationship between a vendor and a consumer or that is otherwise regulated pursuant to rules promulgated by the commissioner;

(III) A policy of insurance covering a seller's or manufacturer's obligations under a warranty; or

(IV) A homeowner's, renter's, private passenger automobile, commercial multi-peril, or similar policy.

(7) "Portable electronics transaction" means:

(a) The sale or lease of portable electronics by a vendor to a customer; or

(b) The sale of a service related to the use of portable electronics by a vendor to a customer.

(8) "Supervising entity" means a business entity that is a licensed insurer or insurance producer that is authorized by an insurer to supervise the administration of a portable electronics insurance program.

(9) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

Source: L. 2012: Entire part added, (HB 12-1071), ch. 25, p. 67, § 1, effective January 1, 2013. **L. 2014:** (6)(b)(I) amended, (HB 14-1199), ch. 204, p. 741, § 1, effective January 1, 2015.

10-4-1502. Licensure of vendors. (1) A vendor shall hold a limited lines producer license issued by the division in accordance with part 4 of article 2 of this title in order to sell or offer coverage under a policy of portable electronics insurance.

(2) A limited lines producer license issued for the purposes of this part 15 authorizes an employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(3) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the commissioner and with ten days' notice to the supervising entity, the supervising entity shall make the registry open to inspection and examination by the commissioner during regular business hours of the supervising entity.

(4) Notwithstanding any other provision of law, a license issued pursuant to this part 15 authorizes the licensee and its employees or authorized representatives to engage in those activities that are permitted in this part 15.

Source: L. 2012: Entire part added, (HB 12-1071), ch. 25, p. 69, § 1, effective January 1, 2013.

10-4-1503. Requirements for sale of portable electronics insurance. (1) At every location where portable electronics insurance is offered to customers, the vendor shall make brochures or other written materials available to a prospective customer that:

(a) Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage;

(b) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(c) Summarize the material terms of the insurance coverage, including:

(I) The identity of the insurer;

(II) The identity of the supervising entity;

(III) The amount of any applicable deductible and how it is to be paid;

(IV) Benefits of the coverage; and

(V) Key terms and conditions of coverage, such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment;

(d) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable if the customer fails to comply with any equipment return requirements; and

(e) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time, and that the person paying the premium will receive a refund of any applicable unearned premium.

(2) An insurer may offer portable electronics insurance on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

(3) A policy of insurance provides primary coverage in the event of a covered loss under more than one policy.

(4) Each insurer shall establish eligibility and underwriting standards for customers electing to enroll in coverage for each portable electronics insurance program.

Source: L. 2012: Entire part added, (HB 12-1071), ch. 25, p. 69, § 1, effective January 1, 2013.

10-4-1504. Authority of vendors of portable electronics. (1) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and are not subject to licensure as an insurance producer under this title if:

(a) The vendor obtains a limited lines producer license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to this section;

(b) The insurer issuing the portable electronics insurance either directly supervises, authorizes, or appoints a supervising entity to supervise the administration of the program, including development of a training program for employees and authorized representatives of the vendors. The supervising entity shall include the following in the training program, which must include employees and authorized representatives of vendors who are directly engaged in the activity of selling or offering portable electronics insurance:

(I) A supplemental education program regarding the portable electronics insurance product that is conducted and overseen by licensed employees of the supervising entity if the training program is provided in electronic format; and

(II) Instruction to each employee or authorized representative about the portable electronics insurance offered to customers and the disclosures required under section 10-4-1503; and

(c) The employee or authorized representative of a vendor does not advertise, represent, or otherwise hold himself or herself out as a nonlimited lines licensed insurance producer.

(2) Notwithstanding any other provision of law, a vendor shall not compensate employees or authorized representatives of a vendor based primarily on the number of customers enrolled for portable electronics insurance coverage, but the vendor may compensate employees or authorized representatives for activities under the limited lines license as long as the compensation is incidental to the employee's or authorized representative's overall compensation.

(3) A vendor may bill and collect charges for portable electronics insurance coverage. A vendor shall separately itemize any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics and any related services. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting the charges are not required to maintain the charges in a segregated account if the vendor is authorized by the insurer to hold the charges in an alternative manner and remits the charges to the supervising entity within sixty days after receipt. All charges received by a vendor from an enrolled customer for the sale of portable electronics insurance are held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

Source: L. 2012: Entire part added, (HB 12-1071), ch. 25, p. 70, § 1, effective January 1, 2013.

10-4-1505. Suspension or revocation of license. (1) If a vendor of portable electronics or its employee or authorized representative violates this part 15, the commissioner may take disciplinary action against the vendor in accordance with part 8 of article 2 of this title. A fine imposed as disciplinary action shall not exceed five thousand dollars in the aggregate for multiple violations arising from the same or similar conduct.

(2) In addition to other penalties authorized by part 8 of article 2 of this title, the commissioner may:

(a) Suspend the privilege of transacting portable electronics insurance pursuant to this part 15 at specific business locations where violations have occurred; and

(b) Suspend or revoke the ability of individual employees or authorized representatives to act under the license.

Source: L. 2012: Entire part added, (HB 12-1071), ch. 25, p. 71, § 1, effective January 1, 2013.

10-4-1506. Termination of portable electronics insurance. (1) Notwithstanding any other provision of law:

(a) (I) Except as specified in subparagraphs (II) and (III) of this paragraph (a), an insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the vendor and enrolled customers with at least thirty days' notice.

(II) An insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen days' notice for nonpayment of premium or for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim under the policy.

(III) An insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(A) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(B) If an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within thirty calendar days after exhaustion of the limit. If notice is not timely sent, enrollment continues notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(b) If the insurer changes the terms and conditions, then the insurer shall provide the vendor with a revised policy or endorsement and shall provide each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating that a change in the terms and conditions has occurred and a summary of the material changes;

(c) When a vendor terminates a portable electronics insurance policy, the vendor shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The insurer shall mail or deliver written notice to the enrolled customer at least thirty days before the termination.

(d) (I) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this part 15 or is otherwise required by law, the insurer, vendor, or other person shall send it in writing within the notice period, if any, specified within the statute or rule requiring the notice or correspondence. Notwithstanding any other provision of law, an insurer, vendor, or other person may send notices and correspondence by either mail or electronic means.

(II) If the notice or correspondence is mailed, the insurer shall send it to the vendor at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last-known mailing addresses on file with the insurer. The insurer or vendor shall maintain proof of mailing in a form authorized or accepted by the United States postal service or other commercial mail delivery service.

(III) If the notice or correspondence is sent by electronic means, the insurer shall send it to the vendor at the vendor's electronic mail address specified for such purpose and to its affected enrolled customers' last-known electronic mail addresses as provided by each enrolled customer to the insurer or vendor. The insurer or vendor shall maintain proof that the notice or correspondence was sent.

(IV) For purposes of this paragraph (d), an enrolled customer's provision of an electronic mail address to the insurer or vendor is consent to receive notices and correspondence by electronic means.

(e) The supervising entity appointed by the insurer may send notice or correspondence required by this section or otherwise required by law on behalf of an insurer or vendor.

Source: L. 2012: Entire part added, (HB 12-1071), ch. 25, p. 72, § 1, effective January 1, 2013.

10-4-1507. Application for license - fees. (1) An applicant for a license under this part 15 shall apply for a license in accordance with section 10-2-404; except that, in lieu of providing information for all officers, partners, and directors as required by section 10-2-404 (2), the required information to be submitted for a license pursuant to this part 15 is limited to the information pertaining to an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with this part 15. If the vendor derives more than fifty percent of its revenue from the sale of portable electronics insurance, the vendor shall provide the location of the home office, name, residence address, and other information required by the commissioner for all officers, directors, and shareholders of record having beneficial ownership of ten percent or more of any class of securities registered under the federal securities laws.

(2) For purposes of complying with section 10-2-404 (2)(d), the licensed producer designated by an applicant is not required to be an officer, partner, employee, or director of the applicant.

(3) An applicant for a license pursuant to this part 15 is exempt from the requirements of sections 10-2-404 (2)(f) and 10-2-406.

(4) Any vendor engaging in portable electronics insurance transactions on or before January 1, 2013, shall apply for licensure within ninety days after January 1, 2013. Any applicant commencing operations after January 1, 2013, shall obtain a license before offering portable electronics insurance.

Source: L. 2012: Entire part added, (HB 12-1071), ch. 25, p. 73, § 1, effective January 1, 2013.

PART 16

CONSUMER GOODS SERVICE CONTRACTS

10-4-1601. Definitions. As used in this part 16, unless the context otherwise requires:

(1) "Administrator" means the person who is responsible for the administration of any service contracts issued by a provider or who is responsible for any submission required by this part 16 on behalf of a provider.

(2) "Commissioner" means the commissioner of insurance.

(3) "Consumer" means a natural person who buys, other than for purposes of resale, any tangible personal property that is distributed in commerce and that is normally used for personal, family, or household purposes and not for business or research purposes.

(4) "Consumer product" means any tangible personal property that is distributed in commerce and is normally used for personal, family, or household purposes, including any tangible personal property intended to be attached to or installed in any real property without regard to whether it is so attached or installed.

(5) "Maintenance agreement" means a contract of limited duration that provides for scheduled maintenance only and does not include repair or replacement.

(6) "Nonoriginal manufacturer's parts" means replacement parts not made for or by the original manufacturer of the property.

(7) "Person" has the same meaning as set forth in section 2-4-401, C.R.S.

(8) "Premium" means the consideration paid to an insurer for a reimbursement insurance policy.

(9) "Provider" means a person who is contractually obligated to the service contract holder under the terms of the service contract.

(10) "Provider fee" means the consideration paid for a service contract.

(11) "Reimbursement insurance company" means an insurer that issues any reimbursement insurance policy.

(12) "Reimbursement insurance policy" means a policy of insurance issued to a provider to either provide reimbursement to the provider under the terms of the insured service contracts issued or sold by the provider or, in the event of the provider's nonperformance, to pay on behalf of the provider all covered contractual obligations incurred by the provider under the terms of the insured service contracts issued or sold by the provider.

(13) "Related service contract seller" means any employee of the provider who is responsible for marketing, selling, or offering to sell service contracts on the provider's behalf.

(14) "Service contract" means a contract or agreement of a specific duration, for a separately stated consideration, to perform the repair, replacement, or maintenance of a consumer product or indemnify the consumer for the repair, replacement, or maintenance of a consumer product for the operational or structural failure of the consumer product due to a defect in materials, workmanship, accidental damage from handling, or normal wear and tear, with or without additional provisions for incidental payment of indemnity under limited circumstances. Service contracts may provide for the repair, replacement, or maintenance of a consumer product for damage resulting from power surges or interruption. Service contracts are not insurance in this state or otherwise regulated under this title.

(15) "Service contract holder" or "contract holder" means a person who is the purchaser or holder of a service contract.

(16) "Warranty" means a warranty that is made solely by the manufacturer, importer, or seller of tangible personal property or services without consideration, that is not negotiated or separated from the sale of the property and is incidental to the sale of the product, and that guarantees either:

(a) Indemnity for defective parts or for damage resulting from a mechanical or electrical breakdown, including labor; or

(b) Other remedial measures, such as repair or replacement of the property or repetition of services.

Source: L. 2014: Entire part added, (HB 14-1199), ch. 204, p. 741, § 2, effective January 1, 2015.

10-4-1602. Exemptions. (1) The following items are exempt from this part 16:

(a) Warranties;

(b) Maintenance agreements;

(c) Service contracts offered by public utilities on their transmission devices to the extent they are regulated by the public utilities commission;

(d) Service contracts sold or offered for sale to persons other than consumers;

(e) Service contracts on tangible property where the tangible property for which the service contract is sold has a purchase price of one hundred dollars or less, exclusive of sales tax;

(f) Home warranty service contracts governed by part 9 of article 10 of title 12;

(g) Motor vehicle service contracts governed by article 11 of title 42, C.R.S.; and

(h) A builder's warranty provided in connection with the sale of a new home.

Source: L. 2014: Entire part added, (HB 14-1199), ch. 204, p. 743, § 2, effective January 1, 2015. **L. 2015:** (1)(f) and (1)(g) amended and (1)(h) added, (HB 15-1223), ch. 81, p. 235, § 7, effective August 5. **L. 2019:** (1)(f) amended, (HB 19-1172), ch. 136, p. 1652, § 37, effective October 1.

10-4-1603. Requirements for sale of consumer goods service contracts - definitions. (1) A provider may appoint an administrator or other designee to be responsible for any or all of the administration of service contracts issued by the provider and for compliance with this part 16.

(2) A provider shall not issue, sell, or offer for sale a service contract unless the provider has:

(a) Provided a receipt for, or other written evidence of, the purchase of the service contract to the contract holder; and

(b) Provided a copy of the service contract to the service contract holder before or within a reasonable period of time after the date of purchase.

(3) Upon a consumer's request, a provider shall provide the consumer with a complete sample copy of the service contract terms and conditions or direct the consumer to a website containing a complete sample of the terms and conditions of the service contract.

(4) (a) A provider shall assure faithful performance to its service contract holders by complying with one or more of the following:

(I) Insuring all service contracts under a reimbursement insurance policy issued by a licensed insurer; or

(II) Maintaining, or together with its parent company maintaining, a net worth or stockholders' equity of at least one hundred million dollars.

(b) For the purposes of subparagraph (II) of paragraph (a) of this subsection (4), a provider shall:

(I) Upon the commissioner's request, provide a copy of the provider's or provider's parent company's most recent form 10-K or form 20-F filed with the federal securities and exchange commission; or

(II) If the company does not file with the federal securities and exchange commission, provide, upon the commissioner's request, a copy of the company's audited financial statements showing a net worth of the provider or its parent company of at least one hundred million dollars; or

(III) If the provider's parent company's form 10-K, form 20-F, or financial statements are filed to meet the requirements of this subsection (4), agree to guarantee the obligations of the provider relating to service contracts sold by the provider in this state.

(c) Except for the requirements set forth in this subsection (4), the commissioner shall require no other financial security requirements for service contract providers.

(5) (a) A provider must permit the service contract holder to void the service contract by returning it within twenty days after the date the service contract is mailed to the service contract holder or within ten days after delivery if the service contract is delivered to the service contract holder at the time of sale. The service contract is void when the service contract holder returns the service contract to the provider, and the provider shall refund to the service contract holder, or credit the account of the contract holder, the full purchase price of the service contract.

(b) A service contract may establish a return period greater than twenty days.

(c) The right to void the service contract is not transferable and applies only to the original service contract purchaser.

(d) The right to void the service contract does not apply if a claim has been made prior to the return of the service contract to the provider.

(e) If a refund of a service contract provider fee is not paid or credited within forty-five days after the return of the service contract under this subsection (5), then a ten percent penalty per month shall be added to the refund.

(6) (a) After the time specified in subsection (5) of this section, or if a claim has been made within that time, a service contract holder may cancel the service contract. Upon cancellation, the provider shall refund to the contract holder one hundred percent of the unearned pro rata provider fee, less any claims made.

(b) A provider may charge a reasonable administrative fee, not to exceed ten percent of the gross provider fee paid by the service contract holder.

(7) (a) The provider may cancel a service contract upon mailing, at least five days prior to the date of cancellation, a written notice to the service contract holder at the contract holder's last-known address contained in the provider's records. The notice must state the effective date of the cancellation and the reason for the cancellation.

(b) Prior notice is not required if the reason for cancellation is nonpayment of the provider fee, a material misrepresentation by the service contract holder to the provider, or a substantial breach by the service contract holder relating to the covered product or its use.

(c) If the provider cancels a service contract for a reason other than nonpayment of the provider fee, the provider shall refund to the service contract holder one hundred percent of the unearned pro rata provider fee, less any claims paid.

(8) (a) Provider fees collected on service contracts are not subject to premium taxes.

(b) Premiums for reimbursement insurance policies are subject to applicable taxes.

(9) (a) Providers, related service contract sellers, and administrators are exempt from any licensing requirements of this state set forth in this title.

(b) (I) Each provider of service contracts sold in Colorado shall register with the commissioner. The registration must contain the provider's name, full corporate address, telephone number, and the name of an individual contact person. In addition, the provider shall designate an agent for service of process in Colorado. The provider shall give the commissioner written notice of any change in this information within thirty days after the change.

(II) Upon initial registration, and annually thereafter, each provider that registers pursuant to this paragraph (b) shall pay to the commissioner a fee, set by the commissioner, in an amount sufficient to defray the commissioner's direct and indirect costs of administering this part 16 and subject to periodic adjustment in accordance with section 24-75-402, C.R.S.

(10) With the exception of the requirements set forth in this part 16, the marketing, sale, offering for sale, issuance, making, proposing to make, and administration of service contracts by providers, related service contract sellers, and administrators are exempt from the requirements of this title.

Source: L. 2014: Entire part added, (HB 14-1199), ch. 204, p. 744, § 2, effective January 1, 2015.

10-4-1604. Obligations of reimbursement insurance companies. (1) Insurers issuing reimbursement insurance policies to providers are deemed to have received the premiums for this insurance upon the payment of provider fees by consumers for service contracts issued by the insured providers.

(2) If the provider does not provide covered service within sixty days after proof of loss by the service contract holder, the contract holder may apply directly to the reimbursement insurance company.

(3) This part 16 does not prevent or limit the right of a reimbursement insurance company that issued a reimbursement insurance policy to seek indemnification or subrogation against a provider if the reimbursement insurance company pays or is obligated to pay the service contract holder sums that the provider was obligated to pay pursuant to the provisions of the service contract.

(4) An insurer that issued a reimbursement insurance policy to a provider shall not terminate the policy until a notice of termination has been mailed or delivered to the insured provider as required by applicable law with a copy of the notice provided to the commissioner. The termination of a reimbursement insurance policy does not reduce the issuer's responsibility for service contracts issued by providers prior to the date of the termination.

Source: L. 2014: Entire part added, (HB 14-1199), ch. 204, p. 746, § 2, effective January 1, 2015.

10-4-1605. Required disclosures - reimbursement insurance policy. (1) Reimbursement insurance policies insuring service contracts issued, sold, or offered for sale must state that the reimbursement insurance company shall either:

(a) Reimburse or pay on behalf of the provider any covered sums the provider is obligated to pay under the service contract; or

(b) In the event of the provider's nonperformance, provide the service that the provider must perform according to the terms and conditions of the service contract.

Source: L. 2014: Entire part added, (HB 14-1199), ch. 204, p. 747, § 2, effective January 1, 2015.

10-4-1606. Required disclosures - service contracts. (1) Service contracts marketed, sold, offered for sale, issued, made, proposed to be made, or administered in this state must be written, printed, or typed in clear, understandable language that is easy to read.

(2) Service contracts insured under a reimbursement insurance policy must contain a statement in substantially the following form: "Obligations of the provider under this service contract are insured under a service contract reimbursement insurance policy." The service contract must also state the name and address of the reimbursement insurance company and disclose to the consumer that if the service contract provider does not provide a covered service within sixty days after proof of loss by the service contract holder, the contract holder may apply directly to the reimbursement insurance company.

(3) Service contracts not insured under a reimbursement insurance policy must contain a statement in substantially the following form: "Obligations of the provider under this service contract are backed by the full faith and credit of the provider."

(4) (a) Service contracts must identify the following:

(I) The name and address of the provider;

(II) The identity of any administrator, if different from the provider;

(III) The service contract seller; and

(IV) The service contract holder to the extent that the name of the service contract holder has been furnished by the service contract holder.

(b) The identities of the parties in this subsection (4) are not required to be preprinted on the service contract and may be added to the service contract at the time of sale.

(5) Service contracts must state the total purchase price and the terms under which the service contract is sold. The purchase price is not required to be preprinted on the service contract and may be negotiated at the time of sale with the service contract holder.

(6) In addition to the other requirements of this section, a service contract must:

(a) Identify the consumer goods covered by the contract;

(b) State the existence of any deductible amount, if applicable;

(c) Specify the merchandise and services to be provided and any limitations, exceptions, or exclusions;

(d) State whether the use of a nonoriginal manufacturer's part is allowed;

(e) State any restrictions governing the transferability of the service contract, if applicable;

(f) State the terms, restrictions, or conditions governing cancellation of the service contract, either by the provider or the service contract holder, prior to the termination or expiration date of the service contract;

(g) Set forth all of the obligations and duties of the service contract holder, such as the duty to protect against any further damage and any requirement to follow the owner's manual; and

(h) State whether or not the service contract provides for or excludes consequential damages or preexisting conditions, if applicable.

Source: L. 2014: Entire part added, (HB 14-1199), ch. 204, p. 747, § 2, effective January 1, 2015.

10-4-1607. Prohibited acts. (1) (a) A provider shall not use in its name:

(I) The words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business; or

(II) A name deceptively similar to the name or description of any insurance or surety corporation, or to the name of any other provider. The word "guaranty" or similar word may be used by a provider.

(b) (I) This section does not apply to a provider that was using any of the prohibited language in its name prior to January 1, 2015.

(II) A provider using the prohibited language in its name shall include in its service contracts a statement in substantially the following form: "This agreement is not an insurance contract."

(2) A provider or its representative shall not in its service contracts or literature make, permit, or cause to be made any false or misleading statement, or deliberately omit any material statement that would be considered misleading if omitted.

(3) A manufacturer or seller of any product shall not require the purchase of a service contract as a condition for the sale of any property.

(4) Nothing in this section limits or prohibits a person from pursuing any claim, cause of action, or right available under Colorado law.

Source: L. 2014: Entire part added, (HB 14-1199), ch. 204, p. 748, § 2, effective January 1, 2015.

10-4-1608. Required record keeping. (1) A provider shall keep accurate accounts, books, and records concerning transactions regulated under this part 16.

(2) A provider's accounts, books, and records must include:

(a) Copies of each type of service contract sold;

(b) The name and address of each service contract holder to the extent that the name and address have been furnished by the service contract holder;

(c) A list of the locations where service contracts are marketed, sold, or offered for sale; and

(d) Written claims files containing at least the dates and descriptions of all claims related to the service contracts.

(3) Except as set forth in subsection (5) of this section, a provider shall retain all records required under this section for at least one year after the specified period of coverage has expired.

(4) The records required under this section may be, but are not required to be, maintained in electronic form or other record-keeping technology. If the records are maintained in other than hard copy, the records must be capable of duplication to legible hard copy at the request of the commissioner.

(5) A provider discontinuing business in this state shall maintain its records until it has discharged all obligations to contract holders in this state.

Source: L. 2014: Entire part added, (HB 14-1199), ch. 204, p. 749, § 2, effective January 1, 2015.

10-4-1609. Enforcement provisions - rules. (1) (a) The commissioner may conduct market examinations or financial examinations of providers under sections 10-1-201 to 10-1-205 to enforce this part 16.

(b) Upon the commissioner's request, the provider shall make available to the commissioner all accounts, books, and records concerning service contracts sold by the provider that are necessary to enable the commissioner to reasonably determine the provider's compliance or noncompliance with this part 16 and the commissioner's rules adopted in furtherance of this part 16.

(2) The provider examined in any financial or market conduct examination shall bear the cost of the examination in accordance with section 10-1-205 (4).

(3) (a) If a provider violates this part 16, the commissioner may take the following disciplinary actions:

(I) Issue an order directing the provider to cease and desist from committing violations of this part 16;

(II) Issue an order prohibiting a service contract provider from selling or offering for sale service contracts in violation of this part 16;

(III) Issue an order imposing a civil penalty on the provider; or

(IV) Any combination of the actions set forth in subparagraphs (I) to (III) of this paragraph (a).

(b) Any civil penalty assessed by the commissioner is limited to not more than five hundred dollars per violation and not more than ten thousand dollars in the aggregate for all violations of a similar nature. For purposes of this paragraph (b), violations are of a similar nature if the violations consist of the same or similar course of conduct, action, or practice, regardless of the number of times the noncompliant act, conduct, or practice occurred.

(c) A person aggrieved by any action taken or penalty assessed under this subsection (3) may request a review in accordance with section 10-1-205 (4).

(4) (a) The commissioner may bring an action in any court of competent jurisdiction for an injunction or other appropriate relief to address threatened or existing violations of this part 16.

(b) An action filed under this subsection (4) may also seek restitution on behalf of persons aggrieved by a violation of this part 16 or orders or rules of the commissioner.

(5) The commissioner may promulgate rules to implement the provisions of this part 16.

Source: L. 2014: Entire part added, (HB 14-1199), ch. 204, p. 749, § 2, effective January 1, 2015.

PART 17

SELF-STORAGE INSURANCE LIMITED LICENSES

10-4-1701. Definitions. As used in this part 17, unless the context otherwise requires:

(1) "Business entity" includes an individual working for or acting on behalf of the self-storage retailer.

(2) "Insurer" means an admitted company or authorized company, as defined in section 10-1-102 (3), approved to transact insurance in this state.

(3) "Occupant" means a person or his or her lessee, successor, or assignee entitled to the use of a self-storage space at a self-service storage facility, to the exclusion of others, under a self-storage rental agreement.

(4) "Offer and disseminate" means to provide general information about self-storage insurance, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other nonlicenseable activities permitted by the state.

(5) "Self-service storage facility" means real property designed and used for the sole purpose of renting or leasing individual storage space to occupants who are given access to a self-storage space for the sole purpose of storing and removing personal property.

(6) "Self-storage insurance" means insurance coverage for property loss incidental to the rental of a self-storage space at a self-service storage facility.

(7) "Self-storage rental agreement" means a written agreement setting forth the terms and conditions governing the use of a self-storage space provided by a self-service storage facility for rent or lease.

(8) "Self-storage retailer" means a business entity that rents self-storage units and may offer and disseminate self-storage insurance as a service to its customers on behalf of and under the direction of a supervising entity.

(9) "Self-storage space" means a designated storage unit or other designated space at a self-service storage facility.

(10) "Supervising entity" means a business entity or person that is a limited line producer, as that term is defined in section 10-2-103 (7.3), authorized by an insurer to supervise a self-storage retailer.

Source: L. 2017: Entire part added, (HB 17-1263), ch. 368, p. 1914, § 1, effective August 9.

10-4-1702. Authority to issue license. (1) A supervising entity must hold a limited lines self-storage insurance producer license issued by the division in accordance with part 4 of article 2 of this title 10 in order to sell, solicit, or negotiate self-storage insurance.

(2) An employee or authorized representative of a self-storage retailer may offer and disseminate self-storage insurance to a customer at each self-storage retailer location at which the employee or authorized representative is supervised by a supervising entity.

(3) An employee or authorized representative of a self-storage retailer shall not advertise, represent, or otherwise hold himself or herself out as a licensed insurer, insurance agent, or insurance producer, and shall neither evaluate nor interpret the technical terms,

benefits, or conditions of the offered self-storage insurance with the occupant or evaluate or provide advice concerning an occupant's existing insurance coverage.

(4) Unless the self-storage retailer is a supervising entity, the self-storage retailer shall not advertise, represent, or otherwise hold itself out as a licensed insurer, insurance agent, or insurance producer, and shall neither evaluate nor interpret the technical terms, benefits, or conditions of the offered self-storage insurance with the occupant or evaluate or provide advice concerning an occupant's existing insurance coverage.

(5) A supervising entity shall maintain a registry of self-storage retailer locations that are authorized to offer and disseminate self-storage insurance coverage in this state. Upon request by the commissioner and with ten days' notice to the supervising entity, the supervising entity shall make the registry open to inspection and examination by the commissioner during regular business hours of the supervising entity.

(6) Notwithstanding any other provision of law, a license issued pursuant to this part 17 authorizes the licensee and its employees or authorized representatives to engage in those activities that are permitted in this part 17.

Source: L. 2017: Entire part added, (HB 17-1263), ch. 368, p. 1915, § 1, effective August 9.

10-4-1703. License - application - restrictions. (1) (a) Before being issued a limited lines self-storage insurance producer license, a person must submit an application for a limited lines self-storage license in accordance with section 10-2-404; except that the applicant is not required to provide the information specified in section 10-2-404 (2).

(b) A supervising entity is responsible for compliance with this part 17. If a self-storage retailer has more than one supervising entity, the commissioner may hold all supervising entities responsible for a violation of this part 17 in accordance with section 10-4-1709. If a self-storage retailer derives more than fifty percent of its revenue from the sale of limited lines self-storage insurance, the self-storage retailer shall provide the location of the self-storage retailer's home office and the name, residential address, and other information required by the commissioner for all officers, directors, and shareholders of record having beneficial ownership of ten percent or more of any class of the self-storage retailer's securities registered under federal securities laws. For purposes of this section:

(I) A supervising entity is not required to be an officer, partner, or director of the self-storage retailer; and

(II) The applicant for a limited lines self-storage insurance producer license pursuant to this part 17 is exempt from the requirements of section 10-2-406.

(c) By July 1, 2018, a person engaged in the sale, solicitation, or negotiation of self-storage insurance before August 9, 2017, shall either apply for a limited lines self-storage insurance producer license or cease engaging in the sale of self-storage insurance. To sell, solicit, or negotiate self-storage insurance on or after July 1, 2018, a person must first obtain a limited lines self-storage insurance producer license. A limited lines self-storage insurance producer license application must be accompanied by a fee prescribed by the commissioner in accordance with section 10-2-413. A limited lines self-storage insurance producer license must be renewed as set forth in section 10-2-408.

(2) A supervising entity may sell, solicit, or negotiate, or offer to sell, solicit, or negotiate, self-storage insurance only in connection with, and incidental to, the rental of a self-storage space in a self-service storage facility. The self-storage insurance may provide coverage only for damage or loss to the personal property of the occupant contained in the self-storage space.

Source: L. 2017: Entire part added, (HB 17-1263), ch. 368, p. 1916, § 1, effective August 9.

10-4-1704. Disclosures to occupant. (1) Before issuing a policy under this part 17, a self-storage retailer shall provide an occupant with a written self-storage insurance policy or self-storage insurance certificate that:

(a) Summarizes clearly and correctly the material terms of coverage offered to the occupant, including the identity and contact information of both the insurer and the supervising entity;

(b) States the benefits of coverage;

(c) States that the self-storage insurance being offered may provide a duplication of insurance coverage already provided by a homeowner's insurance policy or other source of coverage in effect for the occupant. The statement must include a space that allows the occupant to write the occupant's initials to signify the occupant's acknowledgment and understanding of the potential duplication referenced in this subsection (1)(c). The retailer shall specifically bring the potential duplication referenced in this subsection (1)(c) and the opportunity to write the occupant's initials to the occupant's attention by orally offering the occupant an opportunity to read the statement and write the occupant's initials in the space provided.

(d) States the deductible of the self-storage insurance coverage and describes the process for filing a claim;

(e) States whether the policy covers flood damage to stored property; and

(f) States that the self-storage retailer can answer general information about the self-storage insurance offered, including a description of the coverage and premium, but is neither qualified nor authorized to answer technical questions about the terms and conditions of the self-storage insurance offered and disseminated by the supervising entity or to evaluate the adequacy of the occupant's existing insurance coverage, if any.

(2) If the self-storage rental agreement requires the occupant to provide proof of insurance, this insurance coverage requirement may be satisfied if the occupant:

(a) Purchases this coverage from a self-storage retailer; or

(b) Provides evidence of this coverage from another source.

Source: L. 2017: Entire part added, (HB 17-1263), ch. 368, p. 1917, § 1, effective August 9.

10-4-1705. Supervision of issuance - training. (1) A supervising entity shall supervise the administration of the offering and disseminating of self-storage insurance. The supervising entity shall develop a training program for the offering and disseminating of the self-storage insurance and shall require any individual working for or acting on behalf of the self-storage retailer to attend the training.

(2) The training program required pursuant to subsection (1) of this section is mandatory for any individual working for or acting on behalf of a self-storage retailer that is directly engaged in the activity of offering or disseminating self-storage insurance and must include the following:

(a) An education program regarding self-storage insurance that is conducted and overseen by the supervising entity;

(b) Instruction to any individual or business entity working for or acting on behalf of a self-storage retailer about the self-storage insurance offered to occupants and the disclosures required pursuant to this part 17; and

(c) Instruction that any individual or business entity working for or acting on behalf of a self-storage retailer shall not:

(I) Advertise, represent, or otherwise hold himself or herself out as a licensed insurance producer of any kind; or

(II) Evaluate or interpret technical terms, benefits, or conditions of the offered self-storage insurance or evaluate an occupant's existing insurance coverage, if the occupant has any such coverage.

(3) The self-storage retailer may bill and collect premiums for self-storage insurance. These self-storage insurance premiums must be separately itemized if they are not included in the cost of the rental. If the premiums are included in the cost of the rental of the self-storage space, a supervising entity shall ensure that it is clearly and conspicuously disclosed to the occupant that the self-storage insurance is included with the rental fees for the self-storage space. A supervising entity shall establish a separate fiduciary account for the collected coverage premiums but is not required to segregate the individual occupants' premiums in that account. A supervising entity shall remit the coverage premium charges to the insurer within sixty days after receipt. All coverage premiums held by a supervising entity are held in trust by the supervising entity in a fiduciary capacity for the benefit of the insurer.

Source: L. 2017: Entire part added, (HB 17-1263), ch. 368, p. 1918, § 1, effective August 9.

10-4-1706. Compensation. (1) This part 17 does not prohibit the payment or receipt of related compensation in the form of a commission, service fee, brokerage, or other valuable consideration for the sale of self-storage insurance that the supervising entity is authorized to sell, solicit, or negotiate under this part 17 if the supervising entity was duly licensed under this part 17 for the performance of the services and has met all conditions as set forth in this part 17.

(2) Notwithstanding any other provision of law, a self-storage retailer shall not compensate employees based primarily on the number of occupants enrolled for limited lines self-storage insurance, but the self-storage retailer may compensate employees for activities under the limited lines employee's or supervising entity's overall compensation.

Source: L. 2017: Entire part added, (HB 17-1263), ch. 368, p. 1918, § 1, effective August 9.

10-4-1707. Exemption from requirements. Notwithstanding any other provision of this part 17, rule promulgated by the commissioner, or order issued by the commissioner, a

supervising entity is not required to meet the prelicensure educational requirements in section 10-2-201, continuing education requirements in section 10-2-301, or examination requirements in section 10-2-402.

Source: L. 2017: Entire part added, (HB 17-1263), ch. 368, p. 1919, § 1, effective August 9.

10-4-1708. Notification. (1) Notwithstanding any other provision of law:

(a) (I) Whenever written notice or correspondence with respect to a policy is required, the insurer shall send the notice within the notice period, if any, specified by law and may send notices and correspondence by either mail or electronic means. For purposes of this subsection (1)(a)(I), an occupant's provision of an email address to the insurer or supervising entity is consent to receive written notices and correspondence by electronic means.

(II) If the written notice is mailed, the insurer shall send it to the supervising entity at the supervising entity's address as well as to the last-known address of the occupant and shall maintain proof of mailing in a form authorized or accepted by the United States postal service or other commercial mail delivery service.

(III) If the written notice is sent by electronic means, the insurer shall send it to the supervising entity at the supervising entity's email address and to the occupant's last-known email address as provided by the occupant and shall maintain proof that the written notice was sent.

(b) A supervising entity may send any notice or correspondence required by this section or otherwise required by law on behalf of the insurer or self-storage retailer.

Source: L. 2017: Entire part added, (HB 17-1263), ch. 368, p. 1919, § 1, effective August 9.

10-4-1709. Enforcement. (1) The commissioner may, after notice and opportunity for a hearing, respond to a violation of a provision of this part 17 by:

(a) Taking disciplinary action against any supervising entity pursuant to section 10-2-801;

(b) Imposing other penalties, including suspending the license of a supervising entity for a violation of this part 17, as the commissioner considers necessary or convenient to carry out this part 17; or

(c) Suspending or revoking the ability of any individual working for or acting on behalf of a self-storage retailer to act under the limited lines self-storage insurance producer license.

Source: L. 2017: Entire part added, (HB 17-1263), ch. 368, p. 1919, § 1, effective August 9.

PART 18

FAIR ACCESS TO INSURANCE REQUIREMENTS

10-4-1801. Short title. The short title of this part 18 is the "Fair Access to Insurance Requirements Act" or "FAIR Act".

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 830, § 1, effective August 7.

10-4-1802. Legislative declaration. (1) The general assembly finds that:

(a) The impacts of climate change have resulted in an increasing frequency of natural disasters in Colorado;

(b) Colorado experienced three of the largest wildfires in its history in the last five years, and the 2021 Marshall fire resulted in the loss of over one thousand homes and commercial properties;

(c) The growing threats posed by wildfires and other natural disasters in Colorado have put new pressure on the residential and commercial insurance markets; and

(d) If homeowners and commercial property owners are unable to secure insurance coverage for the homes and properties in their communities, the lack of coverage will frustrate and erode those communities' housing and commercial property markets.

(2) The general assembly declares that it is imperative to establish and make available to Colorado homeowners and commercial property owners an insurance plan that:

(a) Ensures stability in the property insurance market for property located in Colorado and provides opportunity for the private insurance market to adapt to changing conditions;

(b) Ensures the availability of property insurance for residents of Colorado; and

(c) Complements the private market by requiring consumers to purchase coverage through the private market when possible.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 830, § 1, effective August 7.

10-4-1803. Definitions. As used in this part 18, unless the context otherwise requires:

(1) "Board" means the board of directors of the FAIR plan association created in section 10-4-1805.

(2) "Commercial property insurance" means insurance against direct loss to commercial property, including buildings and building contents, resulting from the perils of fire, perils covered under extended coverage, vandalism, or malicious mischief. "Commercial property insurance" does not include commercial automobile insurance or farm risks.

(3) "FAIR plan" or "plan" means the fair access to insurance requirements plan established by the board pursuant to section 10-4-1806.

(4) "FAIR plan association" or "association" means the fair access to insurance requirements plan association created in section 10-4-1804.

(5) "Member insurer" means any admitted company that offers or sells any property insurance, including commercial property insurance.

(6) "Property insurance" means insurance against direct loss to residential property, including buildings and building contents, resulting from the perils of fire, perils covered under extended coverage, vandalism, or malicious mischief. "Property insurance" does not include automobile insurance or farm risks.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 831, § 1, effective August 7.

10-4-1804. Fair access to insurance requirements plan association - creation - participation required. (1) There is created the fair access to insurance requirements plan association, or FAIR plan association, which is a nonprofit, unincorporated legal entity. All member insurers are and remain members of the association as a condition of each member insurer's authority to transact insurance business in this state. The association shall perform its functions under a plan of operation established and approved under section 10-4-1807 and shall exercise its powers through a board of directors established under section 10-4-1805.

(1.5) The FAIR plan association is not a department, unit, agency, political subdivision, or instrumentality of the state. All debts, claims, obligations, and liabilities incurred by the association are the debts, claims, obligations, and liabilities of the association only, and are not the debts or pledges of credit of the state or the state's agencies, instrumentalities, officers, or employees. The funds of the association are not part of the general fund of the state, and the state shall not budget for or provide general fund appropriations to the association.

(2) The FAIR plan association is established to provide property insurance coverage, including commercial property insurance, when such coverage is not available from admitted companies. The FAIR plan association is not an insurance company or a person engaged in the business of insurance; except that the plan association must comply with sections 10-1-128; 10-1-136; 10-1-137; 10-3-1104 (1)(h); 10-4-104; 10-4-109.7; 10-4-110; 10-4-110.5; 10-4-110.7; 10-4-110.8 (1), (2), (3), (4), (7), (9), (10), (11)(a), (11)(b), (11)(c)(I), (12), (13)(h), (14), and (16); 10-4-110.9; 10-4-111; 10-4-116; 10-4-117; 10-4-119; 10-4-120; and 10-4-1001 to 10-4-1009.

(3) The FAIR plan association shall:

(a) Establish, offer, and maintain a property insurance and a commercial property insurance policy that satisfy the requirements of the FAIR plan specified in section 10-4-1806; and

(b) Assess and share among member insurers, on a fair and equitable basis, all expenses, income, and losses based on each member insurer's written premium for property and commercial property insurance and in the same proportion that a member insurer's premiums written bear to the aggregate premiums written in the state by all member insurers of the association during the preceding calendar year, consistent with this part 18.

(4) The FAIR plan association may issue property insurance policies, including commercial property insurance policies, and reinsure in whole or in part any such policies, cede any such reinsurance, or transfer risk to other capital markets.

(5) The association shall establish a public website that includes information about the FAIR plan. The website must include a toll-free telephone number that a person may use to obtain information about the plan.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 831, § 1, effective August 7. **L. 2025:** (1), (2), and (3)(b) amended and (1.5) added, (HB 25-1205), ch. 81, p. 338, § 1, effective April 17.

10-4-1805. Fair access to insurance requirements plan association - board of directors - membership - duties - report. (1) (a) The FAIR plan association board of directors

is created as the governing body of the association and to administer the FAIR plan. The board consists of members appointed by the governor as follows:

(I) Two members representing admitted mutual insurers writing property insurance in Colorado;

(II) Two members representing admitted stock insurers writing property insurance in Colorado;

(III) One member representing a Colorado-based insurance trade organization that represents insurers of various property interests;

(IV) One member representing a Colorado-based insurance trade association that represents independent insurance agents licensed to write property and casualty insurance in Colorado;

(V) One member who is an insurance producer licensed pursuant to article 2 of this title 10 to write property and casualty insurance in Colorado; and

(VI) Two members representing the interests of consumers and, to the extent practicable, representing consumer advocacy organizations and diverse geographic areas of the state.

(b) The governor shall make the initial appointments to the board on or before January 1, 2024.

(c) The term of office of board members is three years; except that:

(I) Each board member serves at the pleasure of the governor; and

(II) To ensure staggered membership, of the initial members appointed to the board:

(A) One of the members initially appointed pursuant to subsection (1)(a)(I) or (1)(a)(II) of this section and one of the members initially appointed pursuant to subsection (1)(a)(IV) or (1)(a)(V) of this section shall each serve an initial term of one year; and

(B) The member initially appointed pursuant to subsection (1)(a)(III) of this section and one of the members initially appointed pursuant to subsection (1)(a)(VI) of this section shall each serve an initial term of two years.

(d) A board member may serve four terms.

(e) If a vacancy occurs on the board, the governor shall appoint a new board member to complete the remainder of the board member's term.

(2) The board may, on its own initiative or at the request of the commissioner, amend the plan of operation described in section 10-4-1807, subject to approval by the commissioner.

(3) (a) On or before April 1, 2025, and on or before each April 1 thereafter, the board shall submit to the commissioner, in the form and manner determined by the commissioner, a report concerning the FAIR plan during the preceding calendar year. The report must include information concerning:

(I) The financial condition of the plan;

(II) The number of policies and the coverage available through the plan;

(III) The number and types of claims made under the plan; and

(IV) A description of the sufficiency of coverage under and finances of the plan.

(b) In addition to this annual reporting requirement, the commissioner may require the board to submit quarterly reports or may examine the affairs of the FAIR plan association if the commissioner determines that such action is necessary to ensure the continued solvency of the plan.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 832, § 1, effective August 7.

10-4-1806. FAIR plan - plan requirements - insurer requirements. (1) The board shall establish the FAIR plan. The FAIR plan must satisfy the requirements of this part 18 and any rules promulgated by the commissioner pursuant to this part 18.

(2) Rates for the FAIR plan must:

(a) Not be excessive, inadequate, or unfairly discriminatory;

(b) Be actuarially sound so that revenue generated from premiums is adequate to pay for expected losses, expenses, and taxes;

(c) Reflect the investment income of the plan; and

(d) Reflect the cost of reinsurance or other capital risk transfer markets.

(3) The FAIR plan is subject to the rate filing and review requirements in this article 4.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 834, § 1, effective August 7.

10-4-1807. Plan of operation - mandatory components - amendments - revocation by commissioner - rules. (1) On or before July 1, 2024, the board shall establish and submit to the commissioner a plan of operation for the FAIR plan, which plan of operation satisfies this part 18. The plan of operation and any amendments to the plan of operation become effective upon written approval by the commissioner.

(2) With regard to the FAIR plan, the plan of operation must provide for:

(a) The lines of insurance coverages to be written;

(b) Coverage limits not to exceed seven hundred fifty thousand dollars for property and five million dollars for commercial property owners;

(c) The policy forms to be used;

(d) The perils to be covered;

(e) The establishment of reasonable underwriting standards to determine the eligibility of a risk, including mitigation requirements and property inspections;

(f) The compensation and commissions to be paid to licensed producers offering the FAIR plan;

(g) The time frames for fees to be collected from member insurers;

(h) Assessments against member insurers in the proportion that the premiums received on property and commercial property insurance lines in this state by each assessed member insurer for the three most recent calendar years for which information is available bears to premiums received on property and commercial property insurance lines in this state for such calendar years by all assessed member insurers;

(i) The administration of the plan of operation by the board, including any servicing agreements the board may enter into to support the operations of the FAIR plan association; and

(j) Any other matter necessary or convenient for the purpose of assuring fair access to a FAIR plan.

(3) If the board fails to submit a suitable plan of operation that satisfies this part 18 by July 1, 2024, or fails to timely submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules that are necessary to effectuate the provisions of

this part 18. If the board subsequently submits a suitable plan of operation or suitable amendments, the commissioner shall promulgate rules allowing the plan of operation or amendments to supersede the former rules.

(4) (a) If the commissioner determines that an approved plan of operation is insufficient to satisfy the requirements of this part 18, the commissioner shall provide at least thirty days' notice to the board of the commissioner's intent to revoke approval of all or part of the plan of operation. Within thirty days after the commissioner's notice of intent to revoke all or part of the plan of operation, the board may submit a revised plan of operation or revised part of the plan of operation for the commissioner's review and approval.

(b) If the board fails to submit a revised plan of operation within thirty days after the notice provided pursuant to subsection (4)(a) of this section, the commissioner may make specific changes to the existing plan of operation so that the plan satisfies the requirements of this part 18. The commissioner's changes to the plan of operation do not affect the validity of any policies executed before the date of the change.

(c) If the board subsequently submits a suitable plan of operation to satisfy the requirements of this part 18, that plan of operation or amendments supersedes the commissioner's changes.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 834, § 1, effective August 7. **L. 2025:** (4)(a) amended, (SB 25-300), ch. 428, p. 2440, § 9, effective August 6.

10-4-1808. FAIR plans - requirements for licensed producers. The FAIR plan association shall not sell a policy subject to this part 18 directly to any person or entity. A FAIR plan policy may be issued only though a licensed producer who shall, on behalf of a person or entity, include evidence of at least three declinations of coverage for the property as part of the submittal of an application for a policy with the FAIR plan association.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 835, § 1, effective August 7.

10-4-1809. Assessment of fees. (1) (a) The FAIR plan association may collect fees from member insurers to generate sufficient revenue to start up the association.

(b) A member insurer that pays a fee based on subsection (1)(a) of this section may recoup the amount directly from the member insurers' policyholders.

(c) A member insurer shall not increase premiums based on a fee assessed pursuant to subsection (1)(a) of this section.

(d) The fee described in subsection (1)(a) of this section is not a premium for any purpose, including the computation of the gross premium tax described in section 10-3-209, or a licensed producer's commission.

(2) (a) The FAIR plan association may collect fees from member insurers as needed for the association to meet its financial obligations, subject to approval by the commissioner.

(b) A member insurer assessed a fee pursuant to subsection (2)(a) of this section may recoup the fee directly from the member insurer's policyholders as a surcharge on the policyholders. The surcharge may be recouped over a reasonable amount of time.

(c) A member insurer shall not increase premiums based on a fee assessed pursuant to subsection (2)(a) of this section.

(d) The fee described in subsection (2)(a) of this section is not a premium for any purpose, including the computation of the gross premium tax described in section 10-3-209, or a licensed producer's commission.

(3) If the commissioner determines at any time that the FAIR plan association is or may become unable to meet its financial obligations, the commissioner shall direct the board to collect fees in accordance with subsection (2) of this section.

(4) The FAIR plan association may abate or defer, in whole or in part, a fee assessed to a member insurer if, in the opinion of the board, payment of the fee would endanger the solvency of the member insurer. In the event a fee assessed against a member insurer is abated or deferred, in whole or in part, the amount by which such fee is abated or deferred may be assessed against the other member insurers.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 836, § 1, effective August 7.

10-4-1810. Enforcement - suspension or revocation of certificate of authority - fines. (1) After notice and hearing, the commissioner may suspend or revoke the certificate of authority to transact insurance business in this state of any member insurer that fails to timely pay a fee or to comply with the plan of operation.

(2) As an alternative to suspension or revocation of a certificate of authority, as described in subsection (1) of this section, the commissioner may impose a fine on any member insurer that fails to timely pay a fee or to comply with the plan of operation. The fine must be the greater of:

(a) The amount of the fee plus interest and the commissioner's cost of enforcement; or

(b) Five thousand dollars.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 836, § 1, effective August 7.

10-4-1810.5. Immunity - exceptions - remedies. (1) A member insurer, the FAIR plan association and its agents or employees, the board of directors, and the commissioner or the commissioner's representatives are immune for any action taken by them in the performance of their powers and duties under this part 18.

(2) (a) The exclusive causes of action and remedies available to a policyholder of a FAIR plan policy against the association is for breach of contract or breach of the common law covenant of good faith and fair dealing.

(b) A claim for breach of the common law covenant of good faith and fair dealing against the association requires proof that the association acted unreasonably and that the association knew or recklessly disregarded that the association's actions were unreasonable.

(c) Damages in an action for a breach of the covenant of good faith and fair dealing are limited to compensatory damages for economic and noneconomic losses. A court may award punitive damages only if the association's breach was accompanied by circumstances of fraud, malice, or willful and wanton conduct.

(d) If a policyholder successfully proves that the association breached the covenant of good faith and fair dealing, the policyholder is entitled to attorney fees and costs. If the court finds that an action brought pursuant to this section was frivolous, as provided in article 17 of title 13, the court shall award costs and attorney fees to the association.

Source: L. 2025: Entire section added, (HB 25-1205), ch. 81, p. 339, § 2, effective April 17.

10-4-1811. Appeals - judicial review. Any final action or order of the commissioner issued pursuant to this part 18 is subject to judicial review by the court of appeals pursuant to section 24-4-106 (11).

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 837, § 1, effective August 7.

10-4-1812. Rules. The commissioner may promulgate rules for the implementation of this part 18.

Source: L. 2023: Entire part added, (HB 23-1288), ch. 170, p. 837, § 1, effective August 7.

PART 19

TRAVEL INSURANCE MODEL ACT

10-4-1901. Short title. The short title of this part 19 is the "Travel Insurance Model Act".

Source: L. 2024: Entire part added, (HB 24-1060), ch. 128, p. 430, § 2, effective August 7.

10-4-1902. Scope and purpose. (1) The purpose of this part 19 is to promote the public welfare by creating a comprehensive legal framework within which travel insurance may be sold in this state.

(2) (a) The requirements of this part 19 apply to travel insurance that satisfies all of the following criteria:

(I) The travel insurance covers a resident of this state;

(II) The travel insurance is sold, solicited, negotiated, or offered in this state; and

(III) The policies and certificates are delivered or issued for delivery in this state.

(b) The requirements of this part 19 do not apply to cancellation fee waivers or travel assistance services, except as expressly provided in this part 19.

(3) All other applicable provisions of Colorado's insurance laws continue to apply to travel insurance; except that the specific provisions of this part 19 supersede any general provisions of law that would otherwise be applicable to travel insurance.

Source: L. 2024: Entire part added, (HB 24-1060), ch. 128, p. 430, § 2, effective August 7.

10-4-1903. Definitions. As used in this part 19, unless the context otherwise requires:

(1) "Aggregator site" means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

(2) "Blanket travel insurance" means travel insurance that:

(a) Is issued to an eligible group; and

(b) Provides coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without requiring individual members of the eligible group to pay a charge.

(3) "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A "cancellation fee waiver" is not insurance.

(4) "Eligible group" means, solely for the purposes of travel insurance, a group of two or more persons who are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, including any of the following:

(a) An entity engaged in the business of providing travel or travel services, including tour operators, lodging providers, vacation property owners, hotels, resorts, travel clubs, travel agencies, property managers, cultural exchange programs, and common carriers, as defined in section 40-1-102 (3), or other operator, owner, or lessor of a means of transportation of passengers, including airlines, cruise lines, railroads, steamship companies, and public bus carriers, in which, with regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risks attendant to such travel;

(b) A college, school, or other institution of learning covering students, teachers, employees, or volunteers;

(c) An employer covering any group of employees, volunteers, contractors, board of directors, dependents, or guests;

(d) A sports team, camp, or sponsor of a sports team covering participants, members, campers, employees, officials, supervisors, or volunteers;

(e) A religious, charitable, recreational, educational, or civic organization or branch of the organization covering any group of members, participants, or volunteers;

(f) A financial institution or financial institution vendor, or a parent holding company, trustee, or agent of, or designated by, one or more financial institutions or financial institution vendors, including account holders, credit card holders, debtors, guarantors, or purchasers;

(g) An incorporated or unincorporated association, including a labor union, that has a common interest, constitution, and bylaws and is organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association covering its members;

(h) Subject to the commissioner's permitting the use of a trust and the state's premium tax provisions in section 10-4-1904, a trust or the trustees of a fund that is established, created, or maintained for the benefit of and covering members, employees, or customers of one or more associations meeting the requirements of subsection (4)(g) of this section;

(i) An entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers;

(j) A volunteer fire department, ambulance, rescue, police, court, or any first aid, civil defense, or other similar volunteer group;

(k) A preschool, day care, or other care institution for children, adults, or senior citizens;

(l) An automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers, as defined by their travel status on the rented or leased vehicles; except that the policyholder is the common carrier; the operator, owner, or lessor of a means of transportation; or the automobile or truck rental or leasing company; or

(m) Any other group members that are engaged in a common enterprise or have an economic, educational, or social affinity or relationship and to which issuance of a travel insurance policy would not be contrary to the public interest, as determined by the commissioner.

(5) "Fulfillment materials" means documents sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

(6) "Group travel insurance" means travel insurance issued to any eligible group.

(7) "Limited lines travel insurance producer" has the meaning set forth in section 10-2-414.5 (1)(a).

(8) "Offer and disseminate" has the meaning set forth in section 10-2-414.5 (1)(b).

(9) "Primary certificate holder" means a person that elects and purchases travel insurance under a group travel insurance policy.

(10) "Primary policyholder" means an individual who elects and purchases individual travel insurance.

(11) "Travel administrator" means a person who directly or indirectly underwrites; collects charges, collateral, or premiums from; or adjusts or settles claims of Colorado residents in connection with travel insurance. The following persons are not considered travel administrators so long as they function only as follows:

(a) A person working for a travel administrator, to the extent that the person's activities are subject to the supervision and control of the travel administrator;

(b) An insurance producer selling insurance or engaged in administrative and claims-related activities within the scope of the producer's license;

(c) A travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer in accordance with section 10-2-414.5;

(d) An individual adjusting or settling claims in the normal course of the individual's practice or employment as an attorney and who does not collect charges or premiums in connection with insurance coverage; or

(e) A business entity that is affiliated with a licensed insurer while acting as a travel administrator for the direct and assumed insurance business of an affiliated insurer.

(12) (a) "Travel assistance services" means noninsurance services for which the consumer is not indemnified based on a fortuitous event and where the provision of the service does not result in the transfer or shifting of risk that would constitute the business of insurance.

(b) "Travel assistance services" includes security advisories, destination information, vaccination and immunization information services, travel reservation services, entertainment, activity and event planning, translation assistance, emergency messaging, international legal and

medical referrals, medical case monitoring, coordination of transportation arrangements, emergency cash transfer assistance, medical prescription replacement assistance, passport and travel document replacement assistance, lost luggage assistance, concierge services, and any other service that is furnished in connection with planned travel.

(c) "Travel assistance services" is not insurance and is not related to insurance.

(13) "Travel insurance" has the meaning set forth in section 10-2-414.5 (1)(c).

(14) "Travel protection plan" means a plan that provides one or more of the following: Travel insurance, travel assistance services, and cancellation fee waivers.

(15) "Travel retailer" has the meaning set forth in section 10-2-414.5 (1)(d).

Source: L. 2024: Entire part added, (HB 24-1060), ch. 128, p. 430, § 2, effective August 7.

10-4-1904. Premium tax. (1) An insurer shall pay premium tax, as provided in section 10-3-209, on travel insurance premiums paid by any of the following:

(a) A primary policyholder who is a resident of this state;

(b) A primary certificate holder who is a resident of this state and who elects coverage under a group travel insurance policy; or

(c) Subject to any apportionment rules that apply to the insurer across multiple taxing jurisdictions or that permit the insurer to allocate premiums on an apportioned basis in a reasonable and equitable manner in those jurisdictions, a policyholder of blanket travel insurance:

(I) Who is a resident of this state;

(II) Whose principal place of business is in this state; or

(III) Whose affiliate or subsidiary has a principal place of business in this state, if the affiliate or subsidiary has purchased blanket travel insurance in this state for members of an eligible group.

(2) A travel insurer shall:

(a) Document the state of residence or principal place of business of a policyholder or certificate holder, for purposes of paying premium tax as required in subsection (1) of this section; and

(b) Report as premium only the amount allocable to travel insurance and not any amounts received for travel assistance services or cancellation fee waivers.

Source: L. 2024: Entire part added, (HB 24-1060), ch. 128, p. 433, § 2, effective August 7.

10-4-1905. Travel protection plans. (1) A travel protection plan may be offered for one price for the combined features that the travel protection plan offers in this state if:

(a) The travel protection plan clearly discloses to the consumer, at or prior to the time of purchase, that it includes travel insurance, travel assistance services, or cancellation fee waivers, as applicable, and provides information and an opportunity, at or prior to the time of purchase, for the consumer to obtain additional information regarding the features and pricing of each; and

(b) The fulfillment materials:

(I) Describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan; and

(II) Include the travel insurance disclosures and the contact information for persons providing travel assistance services or cancellation fee waivers, as applicable.

Source: L. 2024: Entire part added, (HB 24-1060), ch. 128, p. 434, § 2, effective August 7.

10-4-1906. Sales practices - definition. (1) Any person offering travel insurance to residents of this state is subject to part 11 of article 3 of this title 10, except as otherwise provided in this section. In the event of a conflict between this part 19 and other provisions of this title 10 regarding the sale and marketing of travel insurance and travel protection plans, the provisions of this part 19 control.

(2) Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is an unfair or deceptive practice pursuant to section 10-3-1104.

(3) (a) All documents provided to consumers prior to the purchase of travel insurance, including but not limited to sales materials, advertising materials, and marketing materials, must be consistent with the travel insurance policy itself, including but not limited to forms, endorsements, policies, rate filings, and certificates of insurance.

(b) For travel insurance policies or certificates that contain preexisting condition exclusions, the person offering the policy or certificate shall provide information and an opportunity to learn more about the preexisting condition exclusions at any time prior to the time of purchase and in the coverage's fulfillment materials.

(c) (I) As used in this subsection (3)(c), "delivery" means handing fulfillment materials to the policyholder or certificate holder or sending fulfillment materials by mail or electronic means to the policyholder or certificate holder.

(II) The fulfillment materials and the information described in section 10-2-414.5 (2)(b)(I) to (2)(b)(IV) shall be provided to a policyholder or certificate holder as soon as practicable following the purchase of a travel protection plan.

(III) Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until at least:

(A) Fifteen days following the date of delivery of the travel protection plan's fulfillment materials by mail; or

(B) Ten days following the date of delivery of the travel protection plan's fulfillment materials by means other than mail.

(d) An insurer shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

(e) When travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it is not an unfair or deceptive practice or other violation of law when an accurate summary or short description of coverage is provided on the web page, so long as the consumer has access to the full provisions of the policy through electronic means.

(4) A person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis shall not do so by using negative option or opt out, which would require a consumer to take an affirmative action to deselect coverage, such as unchecking a box on an electronic form, when the consumer purchases a trip.

(5) It is an unfair or deceptive practice pursuant to section 10-3-1104 to market blanket travel insurance coverage as free.

(6) Where a consumer's destination jurisdiction requires insurance coverage, it is not an unfair or deceptive practice to require that a consumer choose between the following options as a condition of purchasing a trip or travel package:

(a) Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer supplying the trip or travel package; or

(b) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

Source: L. 2024: Entire part added, (HB 24-1060), ch. 128, p. 434, § 2, effective August 7.

10-4-1907. Travel administrators. (1) Notwithstanding any other provision of this title 10, a person shall not act as or represent that the person is a travel administrator for travel insurance in Colorado unless the person is a licensed insurance producer for property and casualty insurance in Colorado for activities permitted under that license.

(2) An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer and is responsible for ensuring that the travel administrator maintains all books and records relevant to the insurer to be made available by the travel administrator to the commissioner upon request.

Source: L. 2024: Entire part added, (HB 24-1060), ch. 128, p. 436, § 2, effective August 7.

10-4-1908. Policy. Notwithstanding any other provision of this title 10, travel insurance is classified and filed for purposes of rate and forms under an inland marine line of insurance; except that travel insurance that provides coverage for sickness, accident, disability, or death occurring during travel, either exclusively or in conjunction with related coverages of emergency evacuation or repatriation of remains, or incidental limited property and casualty benefits, such as travel or trip cancellation, may be filed under either an accident and health line of insurance or an inland marine line of insurance. An insurer offering or selling travel insurance that provides coverage for sickness, accident, disability, or death occurring during travel, emergency evacuation, or repatriation of remains shall hold both property and casualty and accident and health lines of authority.

Source: L. 2024: Entire part added, (HB 24-1060), ch. 128, p. 436, § 2, effective August 7.

10-4-1909. Rules. The commissioner may promulgate any rules necessary to implement this part 19.

Source: L. 2024: Entire part added, (HB 24-1060), ch. 128, p. 436, § 2, effective August 7.

NONADMITTED INSURANCE

ARTICLE 5

Nonadmitted Insurance

Cross references: For additional provisions concerning surplus line insurance, see article 2 of this title.

10-5-101. Short title. This article shall be known and may be cited as the "Nonadmitted Insurance Act".

Source: L. 49: p. 474, § 22. **CSA:** C. 87, § 334. **CRS 53:** § 72-14-17. **C.R.S. 1963:** § 72-13-17. **L. 95:** Entire section amended, p. 491, § 6, effective May 16.

10-5-101.1. Legislative declaration. (1) The general assembly finds and declares that disability, property, and casualty insurance transactions with nonadmitted insurers are so affected with a public interest as to require regulation, taxation, supervision, and control of such transactions and matters relating thereto, as provided in this article 5, in order to:

(a) Protect the insureds and claimants of this state in transactions involving the purchase of insurance from insurers not authorized to transact business in this state;

(b) Provide for the public, except for transactions related to the diligent effort requirements of this article for exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section, to the extent that insurance is not procurable from admitted insurers, orderly, reasonable, and regulated access to such insurance from eligible nonadmitted insurers through qualified, licensed, and supervised surplus line agents and brokers;

(c) Protect the revenues of this state;

(d) Protect regulated, admitted insurers from unregulated and unfair competition by nonadmitted insurers;

(e) Regulate and supervise the effectuation of surplus lines insurance in accordance with the laws of this state and federal law, including the federal "McCarran-Ferguson Act"; and

(f) Maintain reliable insurance markets.

Source: L. 81: Entire section added, p. 537, § 1, effective January 1, 1982. **L. 95:** IP(1), (1)(b), and (1)(e) amended, p. 491, § 7, effective May 16. **L. 99:** (1)(b) amended, p. 388, § 9, effective January 15, 2000. **L. 2012:** (1)(b) amended, (HB 12-1215), ch. 104, p. 355, § 9, effective August 8. **L. 2017:** IP(1) amended, (SB 17-274), ch. 334, p. 1788, § 1, effective August 9.

Cross references: For the McCarran-Ferguson Act, see 59 Stat. 33, 15 U.S.C. §§ 1011 to 1015.

10-5-101.2. Definitions. As used in this article 5, unless the context otherwise requires:

(1) "Affiliate" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.

(2) "Affiliated group" means any group of entities that are all affiliated.

(3) "Broker" means a surplus lines producer duly licensed to export insurance under this article.

(4) "Control" means that an entity has control over another entity if the controlling entity:

(a) Directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote twenty-five percent or more of any class of voting securities of the controlled entity; or

(b) Controls in any manner the election of a majority of the directors or trustees of the controlled entity.

(4.5) "Disability insurance" means insurance that:

(a) Is in excess of policy limits available under a policy issued by an admitted insurer;

(b) Provides income replacement to an insured who becomes an individual with a disability while covered by the disability insurance policy; and

(c) Does not provide coverage for the diagnosis or treatment of an insured's disability.

(5) "Export" means to place with an insurer under this article insurance covering an insured whose home state is Colorado.

(6) "Federal act" means the "Nonadmitted and Reinsurance Reform Act of 2010", 15 U.S.C. sec. 8201 et seq., as amended.

(7) (a) Except as provided in paragraph (b) of this subsection (7),"home state" means, with respect to an insured:

(I) The state in which the insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(II) If one hundred percent of the insured risk is located out of the state referred to in subparagraph (I) of this paragraph (a), the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(b) With respect to affiliated groups, if more than one insured from an affiliated group are named insureds on a single surplus lines insurance contract, "home state" means the home state, as determined pursuant to paragraph (a) of this subsection (7), of the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract.

(8) "Independently procured insurance" means insurance procured directly by a person from a nonadmitted insurer.

(9) "Multistate risk" means a risk covered by a nonadmitted insurer with insured exposures in more than one state.

(10) "Nonadmitted insurance" means any disability, property, or casualty insurance permitted in a state to be placed directly or through a broker with a nonadmitted insurer eligible to accept such insurance. "Nonadmitted insurance" includes independently procured insurance and surplus lines insurance.

(11) "Nonadmitted insurers" means insurers not having a certificate of authority to transact business in this state.

(12) "Person" has the same meaning as set forth in section 2-4-401, C.R.S.

(13) "Surplus lines insurance":

(a) Means coverage placed with an eligible nonadmitted insurer as provided by section 10-5-108; and

(b) Includes disability insurance.

Source: L. 81: Entire section added, p. 538, § 1, effective January 1, 1982. **L. 95:** (1) and (2) amended and (4) added, p. 491, § 8, effective May 16. **L. 2012:** Entire section amended, (HB 12-1215), ch. 104, p. 350, § 1, effective August 8. **L. 2017:** IP, (10), and (13) amended and (4.5) added, (SB 17-274), ch. 334, p. 1788, § 2, effective August 9.

10-5-101.5. Exemptions. (1) The provisions of this article controlling the placing of insurance with nonadmitted insurers shall not apply to reinsurance or, except as to subsection (2) of this section, to the following types of insurance when placed by licensed agents or brokers of this state:

(a) Insurance on vessels or crafts or their hulls or cargoes or on marine builders' risks or marine protection and indemnity or other risks, including strikes and war risks commonly insured under ocean or wet marine forms of policy;

(b) Insurance on subjects located, resident, or to be performed wholly outside of this state or on vehicles or aircraft owned and principally garaged outside this state;

(c) Insurance on the operations of railroads engaged in transportation in interstate commerce and their property used in such operations;

(d) Insurance on aircraft owned or operated by manufacturers of aircraft or on aircraft operated in commercial scheduled interstate flight or the cargo of such aircraft or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of such aircraft;

(e) Insurance on satellites or other devices intended for launch beyond the earth's atmosphere.

(2) Brokers placing any insurance referred to in subsection (1) of this section shall keep a full and true record of each such coverage in detail as required of surplus line insurance under this article. The record shall be preserved for not less than three years after the effective date of the insurance; shall be kept in the broker's office and open to the commissioner's examination and on forms designated and furnished by the commissioner; and shall contain a report of all such coverages so placed in a designated calendar year.

Source: L. 81: Entire section added, p. 538, § 1, effective January 1, 1982. **L. 2005:** Entire section amended, p. 735, § 1, effective January 1, 2006.

10-5-102. Validity of certain contracts. A contract of insurance effectuated by a nonadmitted insurer in violation of the provisions of this article shall be voidable except at the instance of the insurer.

Source: L. 49: p. 467, § 1. **CSA:** C. 87, § 318. **CRS 53:** § 72-14-1. **C.R.S. 1963:** § 72-13-1. **L. 95:** Entire section amended, p. 492, § 9, effective May 16.

10-5-103. Conditions for export. (1) If certain insurance coverages cannot be procured from admitted insurers, such coverages, designated in this article as "surplus lines", may be procured from nonadmitted insurers, subject to the following conditions:

(a) The insurance must be procured through a licensed broker.

(b) The full amount of insurance required shall not be procurable, after diligent effort has been made to do so, from among admitted insurers authorized to transact and actually transacting that kind of insurance in this state; and placing the insurance with a nonadmitted insurer shall not be for the purpose of securing a lower premium rate than that which would be accepted by an admitted insurer unless the premium rate quoted by the admitted insurer is more than ten percent higher than that quoted by the nonadmitted insurer.

(c) At the time of the procuring of any such insurance, an affidavit setting forth facts referred to in paragraph (b) of this subsection (1) must be executed by the broker. Such affidavit shall be filed with the commissioner within thirty days after the insurance is procured. In lieu thereof, the commissioner may provide for simplified monthly reporting of coverages procured pursuant to this article.

(2) The diligent effort requirements of this section shall not apply to transactions with exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 49: p. 467, § 2. **CSA:** C. 87, § 319. **CRS 53:** § 72-14-2. **C.R.S. 1963:** § 72-13-2. **L. 81:** Entire section R&RE, p. 538, § 2, effective January 1, 1982. **L. 95:** IP(1) and (1)(b) amended, p. 492, § 10, effective May 16. **L. 99:** (2) added, p. 388, § 10, effective January 15, 2000.

10-5-103.5. Producing broker's affidavit. Any broker exporting insurance under this article, at the request of any other licensed agent or broker, may accept an affidavit executed by such other agent or broker, in such form as may be prescribed or accepted by the commissioner, as evidence that such insurance was eligible for export under section 10-5-103. Except as the commissioner may otherwise provide, the broker shall file or cause to be filed such affidavit with the commissioner within thirty days after the insurance was so procured.

Source: L. 81: Entire section added, p. 539, § 3, effective January 1, 1982.

10-5-104. Endorsement of contract. Every insurance contract procured and delivered as a surplus line coverage pursuant to this article shall be initialed by or bear the name of the surplus line broker who procured it and shall have stamped upon it the following: "This contract is delivered as a surplus line coverage under the 'Nonadmitted Insurance Act'. The insurer issuing this contract is not licensed in Colorado but is an eligible nonadmitted insurer. There is no protection under the provisions of the 'Colorado Insurance Guaranty Association Act'."

Source: L. 49: p. 468, § 3. **CSA:** C. 87, § 320. **CRS 53:** § 72-14-3. **C.R.S. 1963:** § 72-13-3. **L. 95:** Entire section amended, p. 492, § 11, effective May 16. **L. 2012:** Entire section amended, (HB 12-1215), ch. 104, p. 355, § 10, effective August 8.

Cross references: For the "Colorado Insurance Guaranty Association Act", see part 5 of article 4 of this title 10.

10-5-105. Surplus line insurance valid. Insurance contracts procured as surplus line coverage from nonadmitted insurers in accordance with this article shall be fully valid and enforceable as to all parties and shall be given recognition in all matters and respects to the same effect as like contracts issued by admitted insurers.

Source: L. 49: p. 468, § 4. **CSA:** C. 87, § 321. **CRS 53:** § 72-14-4. **C.R.S. 1963:** § 72-13-4. **L. 95:** Entire section amended, p. 492, § 12, effective May 16.

10-5-106. When export declared eligible. The commissioner may, by rule, declare eligible for export generally, notwithstanding the provisions of section 10-5-103 (1)(b) and (1)(c), any class of insurance coverage or risk for which the commissioner finds that there is no reasonable or adequate market among insurers licensed in this state. For the purposes of this section, the diligent effort requirements of this article shall not apply to transactions with exempt commercial policyholders, as defined pursuant to section 10-4-1402 and rules adopted by the commissioner pursuant to that section.

Source: L. 49: p. 468, § 5. **CSA:** C. 87, § 322. **CRS 53:** § 72-14-5. **C.R.S. 1963:** § 72-13-5. **L. 77:** Entire section repealed, p. 506, § 7, effective January 1, 1978. **L. 81:** Entire section RC&RE, p. 539, § 4, effective January 1, 1982. **L. 92:** Entire section amended, p. 1491, § 20, effective July 1. **L. 99:** Entire section amended, p. 388, § 11, effective January 15, 2000.

10-5-107. Brokers may accept business from producers. A licensed surplus line broker may accept and place surplus line business for any insurance producer licensed in this state for the kind of insurance involved and may compensate such agent or broker therefor.

Source: L. 49: p. 468, § 6. **CSA:** C. 87, § 323. **CRS 53:** § 72-14-6. **C.R.S. 1963:** § 72-13-6. **L. 2001:** Entire section amended, p. 1213, § 38, effective January 1, 2002.

10-5-108. Placement of surplus lines insurance. (1) A broker shall not place any coverage with a nonadmitted insurer unless, at the time of placement, the nonadmitted insurer meets all applicable eligibility requirements contained in the federal act or is an insurance exchange, Lloyds plan, or group of incorporated insurers under common administration that has been approved by the commissioner and is included on the list of eligible nonadmitted insurers prepared by the commissioner at least annually. To be placed on the eligible list, the nonadmitted insurer shall:

(a) Submit a current year's application, fees as prescribed by sections 10-3-207 and 24-31-104.5, C.R.S., and other information required by the commissioner. In the case of an insurance exchange, the nonadmitted insurer shall submit an aggregate combined annual statement of all underwriting syndicates operating during the period reported, in addition to individual annual statements for each syndicate.

(b) (I) In the case of a foreign insurer, meet all applicable eligibility requirements contained in the federal act. The commissioner may approve an insurer with less than the

required minimum requirements upon an affirmative finding of acceptability by the commissioner. The finding must be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. The commissioner shall not make an affirmative finding of acceptability when the insurer's capital and surplus is less than four million five hundred thousand dollars.

(II) In the case of an "insurance exchange" created by the laws of a state other than this state, the syndicates of the exchange shall have and maintain, under terms acceptable to the commissioner, capital and surplus of not less than seventy-five million dollars in the aggregate. The insurance exchange shall maintain, under terms acceptable to the commissioner, not less than fifty percent of the policyholder surplus of each syndicate in a custodial account accessible to the exchange or its domiciliary commissioner in the event of insolvency or impairment of the individual syndicate. In addition, each individual syndicate to be eligible to accept surplus lines insurance placements from this state shall meet either of the following requirements:

(A) For insurance exchanges that maintain funds in an amount of not less than fifteen million dollars for the protection of all exchange policyholders, the syndicate shall have and maintain, under terms acceptable to the commissioner, minimum capital and surplus of not less than five million dollars; or

(B) For insurance exchanges that do not maintain funds in an amount of not less than fifteen million dollars for the protection of all exchange policyholders, the syndicate shall maintain, under terms acceptable to the commissioner, minimum capital and surplus of not less than the minimum capital and surplus requirements under the laws of its domiciliary jurisdiction or fifteen million dollars, whichever is greater.

(c) (I) In the case of an alien insurer, as defined in section 10-3-301 (1), maintain status on the current national association of insurance commissioners' international insurers department listing;

(II) In the case of a Lloyd's plan or other similar unincorporated group of individual insurers, or a combination of both unincorporated and incorporated insurers, such alien insurer shall have and maintain a trust fund in the United States, in an amount of not less than one hundred million dollars, which trust fund shall be available for the benefit of United States surplus lines policyholders of any member of the group. The group shall, in addition, maintain in the United States a trust fund or trust funds in an amount satisfactory to the commissioner that is not less than the amount required by the law of the state where the trust fund or trust funds are located. The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members. The trust funds shall be maintained in an irrevocable trust account in the United States in a qualified financial institution and shall consist of cash, securities, letters of credit, or investments of substantially the same character and quality as those that are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state, and the trust instrument representing the surplus portion of the trust deposit shall satisfy the requirements of the standard trust agreement required for listing with the national association of insurance commissioners' international insurers department.

(III) In the case of a group of incorporated insurers under common administration that has continuously transacted an insurance business outside the United States for at least three

years immediately before May 16, 1995, and that submits to this state's authority to examine its books and records and bears the expense of the examination, have and maintain an aggregate policyholders' surplus of ten billion dollars and have and maintain in trust a surplus in the amount of one hundred million dollars, all of which surplus funds shall be available for the benefit of United States surplus lines policyholders of any member of the group. Each insurer shall individually maintain capital and surplus of not less than twenty-five million dollars per company. The trust funds shall satisfy the requirements of the standard trust agreement requirement for listing with the national association of insurance commissioners' international insurers department, shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, and shall consist of cash, securities, letters of credit, or investments of substantially the same character and quality as those that are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state. Additionally, each member of the group shall make available to the commissioner an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant.

(d) (Deleted by amendment, L. 95, p. 493, § 13, effective May 16, 1995.)

(2) A surplus line broker who places insurance with a nonadmitted insurance company that does not comply with this article is subject to a penalty of up to ten thousand dollars as determined by the commissioner and the surplus line broker's license may be revoked.

Source: L. 49: p. 469, § 7. **CSA:** C. 87, § 324. **CRS 53:** § 72-14-7. **C.R.S. 1963:** § 72-13-7. **L. 71:** p. 725, § 1. **L. 73:** p. 856, § 1. **L. 75:** (1) R&RE, p. 342, § 1, effective July 1. **L. 81:** (1) amended, p. 539, § 5, effective January 1, 1982. **L. 91:** (1) amended, p. 1232, § 6, effective June 5. **L. 92:** (1) amended, p. 1492, § 21, effective July 1. **L. 93:** (1)(c) amended, p. 485, § 2, effective April 26. **L. 95:** Entire section amended, p. 493, § 13, effective May 16. **L. 98:** (1)(c)(II) amended, p. 227, § 1, effective April 10. **L. 2010:** (1)(a) amended, (HB 10-1385), ch. 204, p. 883, § 4, effective May 5. **L. 2012:** (1)(a) amended, (SB 12-110), ch. 158, p. 561, § 6, effective July 1; IP(1), (1)(a), IP(1)(b), (1)(b)(I), (1)(c)(I), and (2) amended, (HB 12-1215), ch. 104, p. 351, § 2, effective August 8.

Editor's note: Amendments to subsection (1)(a) by House Bill 12-1215 and Senate Bill 12-110 were harmonized.

10-5-109. Records of surplus line broker. Each licensed surplus line broker shall keep in the broker's office a full and true record of each surplus line contract procured by the broker, including a copy of the daily report, if any, showing such of the following items as may be applicable: Amount of the insurance; gross premiums charged; return premium paid, if any; rate of premium charged upon the several items of property; effective date of the contract and the terms thereof; name and address of the insurer; name and address of the insured; brief general description of property insured and where located; other information as may be required by the commissioner. The record shall at all times be open to examination by the commissioner.

Source: L. 49: p. 469, § 8. **CSA:** C. 87, § 325. **CRS 53:** § 72-14-8. **C.R.S. 1963:** § 72-13-8. **L. 2001:** Entire section amended, p. 1213, § 39, effective January 1, 2002.

10-5-110. Statement - rules. (1) Each surplus line broker and every person that enters into an independent procurement for nonadmitted insurance shall file with the commissioner a verified statement of all insurance transacted by the broker or other person during the preceding reporting period. The commissioner shall, by rule, determine the reporting period.

(2) The statement must be on forms as prescribed and furnished by the commissioner, and must show: Gross amount of each kind of insurance transacted, aggregate gross premiums charged, aggregate of returned premiums paid to insureds, aggregate of net premiums, and additional information as required by the commissioner.

Source: L. 49: p. 469, § 9. **CSA:** C. 87, § 326. **CRS 53:** § 72-14-9. **C.R.S. 1963:** § 72-13-9. **L. 2012:** Entire section amended, (HB 12-1215), ch. 104, p. 353, § 3, effective August 8.

10-5-111. Tax on premiums - filing system - division to contract with third parties - rules - definition. (1) Each surplus line broker and every person that enters into an independent procurement for nonadmitted insurance shall remit to the division a tax on the net premiums, exclusive of sums collected to cover federal and other state taxes and examination fees, on nonadmitted insurance subject to tax under this article during the preceding reporting period as shown by the statement filed with the commissioner. The net premiums must be taxed at the rates described in section 10-5-111.5.

(2) If a surplus line policy or independently procured policy covers an insured whose home state is Colorado, and that policy covers risks or exposures located outside of Colorado, the tax payable is computed using the allocation method contained in section 10-5-111.5.

(3) (a) All taxes, penalties, fines, fees, and associated filings required pursuant to this section must be submitted to the division through a secure web-based application system identified by the division. The commissioner may enter into a contract with a qualified third party, including the Florida Surplus Line Services Office, for a secure web-based application system that would allow taxpayers to file taxes for multiple states on a single web-based application system. The third party may charge the taxpayer a nominal fee for this service that is reasonably related to the overall cost of the service of collecting filings and payments and transmitting those filings and payments to the division. A fee charged by the third party as part of this subsection (3) is not subject to this section, section 10-3-207, section 10-3-209 (4)(a), or section 10-5-111.5 (1).

(b) Pursuant to article 4 of title 24, the commissioner may promulgate rules necessary to implement, operate, and enforce this subsection (3).

(c) In contracting with a qualified third party for a secure web-based application system described in this subsection (3), the commissioner is exempt from the "Procurement Code", articles 101 to 112 of title 24.

(d) As used in this subsection (3), "taxpayer" means a person subject to tax under this section 10-5-111.

Source: L. 49: p. 470, § 10. **CSA:** C. 87, § 327. **CRS 53:** § 72-14-10. **C.R.S. 1963:** § 72-13-10. **L. 92:** (1) amended, p. 1761, § 2, effective February 28. **L. 2012:** Entire section amended, (HB 12-1215), ch. 104, p. 353, § 4, effective August 8. **L. 2024:** (3) added, (HB 24-1119), ch. 38, p. 137, § 3, effective March 22.

Cross references: (1) For additional taxes required by this article 5, see § 10-3-209.

(2) For the legislative declaration in HB 24-1119, see section 1 of chapter 38, Session Laws of Colorado 2024.

10-5-111.5. Allocation of premium tax. (1) In determining the amount of tax payable to Colorado, the entire amount of tax payable at a rate of three percent on the net premiums is presumed to be owed to Colorado; except that, for those multistate risks involving states that have entered into either a compact or a tax-sharing agreement with Colorado to share the tax, the premium tax rate and the amounts allocated to the other states are subject to determination according to the terms of the compact or agreement.

(2) The commissioner may participate in tax-sharing agreements to collect and disburse funds in accordance with subsection (1) of this section, if the purposes of the tax-sharing agreement are limited to:

(a) Facilitating the payment and allocation of premium taxes on nonadmitted insurance for multistate risks among states participating in the agreement;

(b) Adopting uniform requirements, forms, and procedures that facilitate the reporting, payment, collection, and allocation of premium taxes for nonadmitted insurance for multistate risks;

(c) Coordinating the reporting of premium taxes and transaction data of multistate risks among the states participating in the agreement; and

(d) Establishing a mechanism to facilitate the receipt and distribution of premium taxes and transaction data related to nonadmitted insurance of multistate risks.

Source: L. 2012: Entire section added, (HB 12-1215), ch. 104, p. 353, § 5, effective August 8.

10-5-112. Penalty for failure to comply. If any surplus line broker fails to file the annual statement, or fails to remit the tax provided by section 10-5-111, prior to the first day of April after the tax is due, the broker shall be liable for a fine of twenty-five dollars for each day of delinquency commencing with the first day of April. The tax may be collected by distraint, or the tax and fine may be recovered by an action instituted by the commissioner in any court of competent jurisdiction.

Source: L. 49: p. 470, § 11. **CSA:** C. 87, § 328. **CRS 53:** § 72-14-11. **C.R.S. 1963:** § 72-13-11. **L. 2005:** Entire section amended, p. 736, § 2, effective January 1, 2006.

10-5-113. Revocation of broker's license. (1) The commissioner may revoke any surplus line broker's license:

(a) If the broker fails to file the annual statement or to remit the tax as required by this article; or

(b) If the broker fails to keep the records, or to allow the commissioner to examine the broker's records as required by this article; or

(c) For any of the causes for which a general broker's license may be revoked.

(2) The commissioner may suspend or revoke any such license whenever the commissioner deems suspension or revocation to be for the best interest of the people of this state.

(3) The procedures provided by law for the suspension or revocation of general brokers' licenses shall be applicable to suspension or revocation of a surplus line broker's license.

(4) No broker whose license has been so revoked or suspended shall again be so licensed within one year thereafter or until any fines or delinquent taxes owing by the broker have been paid.

Source: L. 49: p. 470, § 12. **CSA:** C. 87, § 329. **CRS 53:** § 72-14-12. **C.R.S. 1963:** § 72-13-12. **L. 95:** IP(1) amended, p. 496, § 14, effective May 16. **L. 2001:** (1)(b) amended, p. 1213, § 40, effective January 1, 2002. **L. 2005:** (1)(a), (2), and (4) amended, p. 736, § 3, effective January 1, 2006.

Cross references: For limitation on revocation of licenses, see article 4 of title 24; for the procedure for revocation of broker's license, see part 8 of article 2 of this title 10.

10-5-114. Actions against insurer - service. (1) A nonadmitted insurer may be sued, upon any cause of action arising in this state under any contract issued by it as a surplus line contract, pursuant to this article, in the district court of the county in which the cause of action arose.

(2) Service of legal process against the insurer may be made in any such action by service upon the commissioner. The commissioner shall forthwith mail the documents of process served, or a true copy thereof, to the person designated by the insurer pursuant to rule of the commissioner for the purpose by prepaid certified mail with return receipt requested. The insurer shall have forty days from the date of service upon the commissioner within which to plead, answer, or otherwise defend the action. Upon service of process upon the commissioner in accordance with this provision, the court shall be deemed to have jurisdiction in personam of the insurer.

(3) A nonadmitted insurer issuing such policy shall be deemed thereby to have authorized service of process against it, in the manner and to the effect as provided in this section, and to have appointed the commissioner as its agent for service of process issuing upon any cause of action arising in this state under any such policy. Any such policy shall contain a provision stating the substance of this section and designating the person to whom the commissioner shall mail process as provided in subsection (2) of this section.

Source: L. 49: p. 471, § 13. **CSA:** C. 87, § 330. **CRS 53:** § 72-14-13. **C.R.S. 1963:** § 72-13-13. **L. 73:** p. 848, § 4. **L. 86:** (2) amended, p. 556, § 7, effective July 1. **L. 89:** (2) amended, p. 438, § 9, effective July 1. **L. 95:** (1) and (3) amended, p. 496, § 15, effective May 16. **L. 98:** (2) amended, p. 228, § 2, effective April 10. **L. 2001:** (2) amended, p. 1213, § 41, effective January 1, 2002.

Cross references: For service of legal process, see § 10-3-1003.

10-5-115. Authority of commissioner - assistance of brokers' association. (1) The commissioner shall maintain such facilities as may be necessary to carry out the purposes of this article.

(2) The commissioner may rely upon the advice and assistance of a duly constituted association of brokers in carrying out the purposes of this article, if the association files with the commissioner:

(a) A copy of the association's constitution and articles of agreement or association or the association's certificate of incorporation and bylaws and any rules or regulations governing the association's activities;

(b) (Deleted by amendment, L. 95, p. 496, § 16, effective May 16, 1995.)

(c) A list of the association's members;

(d) The name and address of a resident of this state upon whom notices or orders of the commissioner or process issued by the commissioner may be served.

(2.5) The commissioner may examine the association's records concerning the functions or duties performed on behalf of the commissioner by the association.

(3) The association shall provide a means for the examination of all surplus line coverages written in this state to determine whether such coverages comply with the law and such rules or regulations as may be issued by the commissioner.

(4) The commissioner may refuse to accept, or may suspend or revoke the acceptance of, an association for any of the following reasons:

(a) It reasonably appears that the association will not be able to carry out the purpose of this article;

(b) The association does not maintain and enforce rules or regulations which will assure that members of the association and persons associated with those members will comply with this article, other applicable articles of this title, and rules or regulations promulgated under either;

(c) The rules or regulations of the association do not assure a fair representation of its members in the selection of directors and in the administration of its affairs;

(d) The rules or regulations of the association do not provide for an equitable allocation of reasonable dues, fees, and other charges among members;

(e) The rules or regulations of the association impose an undue burden on competition;

(f) The association fails to meet other applicable requirements prescribed in this article.

(5) An association shall deny membership to any person who is not a licensee.

(6) A broker shall cooperate with the association and the commissioner of insurance in fulfilling the broker's statutory responsibilities under this article.

(7) There shall not be liability on the part of, nor shall a cause of action of any nature arise against, the association or its agents, employees, or directors or authorized representatives of the commissioner for actions taken or omitted by them in the performance of their powers and duties under this section.

(8) (a) Upon request from the association, the commissioner may approve the levy of an examination fee of not more than one percent of premiums charged pursuant to this article for the operation of the association to the extent that such operation relieves the commissioner of duties otherwise required of the commissioner under this article.

(b) The association may revoke the membership and the commissioner may revoke the license in this state of any licensee who fails to pay the examination fee when due, if the examination fee has been approved by the commissioner.

Source: L. 49: p. 472, § 14. **CSA:** C. 87, § 331. **CRS 53:** § 72-14-14. **C.R.S. 1963:** § 72-13-14. **L. 81:** Entire section R&RE, p. 540, § 6, effective January 1, 1982. **L. 95:** (2)(b), (6), and (7) amended and (2.5) added, p. 496, § 16, effective May 16; IP(2) amended, p. 1109, § 56, effective May 31. **L. 2010:** IP(2) amended, (HB 10-1220), ch. 197, p. 853, § 10, effective July 1.

10-5-116. Records produced on order. Every person for whom insurance is placed with a nonadmitted insurer pursuant to or in violation of this article, upon the commissioner's order, shall produce for the commissioner's examination all policies and other documents evidencing the insurance and shall disclose to the commissioner the amount of the gross premiums paid or agreed to be paid for the insurance. For each refusal to obey such order, such person shall be liable to a fine of not more than ten thousand dollars.

Source: L. 49: p. 472, § 15. **CSA:** C. 87, § 332. **CRS 53:** § 72-14-15. **C.R.S. 1963:** § 72-13-15. **L. 95:** Entire section amended, p. 497, § 17, effective May 16. **L. 2005:** Entire section amended, p. 736, § 4, effective January 1, 2006.

10-5-117. Rules and regulations. The commissioner may make and publish reasonable rules and regulations consistent with this article in respect to the transactions governed thereby and for the basis for his determination under this article.

Source: L. 49: p. 472, § 16. **CSA:** C. 87, § 333. **CRS 53:** § 72-14-16. **C.R.S. 1963:** § 72-13-16.

Cross references: For rule-making procedures, see article 4 of title 24.

10-5-118. Notice provisions not applicable to surplus lines. The notice provisions in sections 10-4-109.7, 10-4-110, 10-4-110.5, and 10-4-110.7 shall not be applicable to insurance companies authorized pursuant to this article to write surplus lines insurance in Colorado.

Source: L. 87: Entire section added, p. 434, § 9, effective May 1.

10-5-119. Disclosures regarding claims-made policies by surplus line brokers or insurers. (1) In the event that a contract procured or placed by a Colorado surplus line broker is on a claims-made or other nonoccurrence policy form, the broker or the nonadmitted insurer shall stamp on the face of the policy a clear disclosure, as prescribed by the commissioner, which shall be in predominate type.

(2) The disclosure requirement in subsection (1) of this section shall not apply to transactions with exempt commercial policyholders as defined by section 10-4-1402 and the rules adopted by the commissioner pursuant to such section.

Source: L. 87: Entire section added, p. 434, § 9, effective May 1. **L. 92:** Entire section amended, p. 1494, § 22, effective July 1. **L. 95:** Entire section amended, p. 497, § 18, effective May 16. **L. 2005:** Entire section amended, p. 736, § 5, effective January 1, 2006.

CAPTIVE INSURANCE COMPANIES

ARTICLE 6

Captive Insurance Companies

10-6-101. Short title. This article shall be known and may be cited as the "Colorado Captive Insurance Company Act".

Source: L. 72: p. 428, § 1. **C.R.S. 1963:** § 72-36-1.

10-6-102. Legislative declaration. It is the policy of the general assembly and the intent and purpose of this article to simplify the procedures for organizing and regulating the operations of captive insurance companies within the state of Colorado, to encourage the formation of such companies while retaining the integrity, financial solvency, and stability of insurance operations, and thereby promoting economic development and the general welfare of the people of the state of Colorado.

Source: L. 72: p. 428, § 1. **C.R.S. 1963:** § 72-36-2. **L. 89:** Entire section amended, p. 462, § 1, effective April 15. **L. 94:** Entire section amended, p. 541, § 1, effective April 6.

10-6-103. Definitions. As used in this article, unless the context otherwise requires:

(1) "Affiliated company" means any company that directly or indirectly owns or controls a pure captive insurance company and any company owned or controlled, directly or indirectly, by a parent or subsidiary.

(2) "Captive insurance company" means a pure captive insurance company or a group captive insurance company.

(3) "Commissioner" means the commissioner of insurance.

(4) "Group" means any association of individual professional practitioners, corporations, partnerships, limited liability companies, or associations with substantially similar or related risks, the members of which collectively own, control, or hold with power to vote all of the outstanding voting securities or other ownership interest of a group captive insurance company.

(5) "Group captive insurance company" means any domestic insurance company licensed under the provisions of this article for the purpose of making insurance and reinsurance, including any company organized under the federal "Liability Risk Retention Act of 1986", as amended, 15 U.S.C. secs. 3901 to 3905. Such insurance and reinsurance shall be limited to the risks, hazards, and liabilities of its group members and employee benefits coverages.

(6) "Impairment" means that a captive insurance company's permissible assets are less than its liabilities, including as a liability the aggregate amount of any outstanding capital stock, or that its capital and surplus are less than the capital and surplus established pursuant to section 10-6-116.

(7) "Insolvency" means that a captive insurance company's permissible assets are less than all of its liabilities, excluding from such liabilities the aggregate amount of any outstanding capital stock.

(8) "Parent" means a corporation, partnership, or individual who directly or indirectly owns, controls, or holds with power to vote more than fifty percent of the outstanding voting securities or other ownership interest of a pure captive insurance company.

(9) "Pure captive insurance company" means any domestic insurance company licensed under the provisions of this article for the purpose of making insurance and reinsurance. Such insurance and reinsurance shall be limited to the risks, hazards, and liabilities of its parent and affiliated entities along with employee benefits coverages.

Source: L. 72: p. 429, § 1. **C.R.S. 1963:** § 72-36-4. **L. 76:** (3), (4), and (9) amended, p. 380, § 1, effective April 6. **L. 87:** (3), (4), (5), and (7) amended and (6.1) to (6.3) added, p. 435, § 1, effective May 22. **L. 89:** (3) and (10) amended, p. 462, § 2, effective April 15. **L. 91:** (9) amended, p. 1224, § 2, effective May 24. **L. 94:** Entire section R&RE, p. 541, § 2, effective April 6.

10-6-104. Scope of article. (Repealed)

Source: L. 72: p. 428, § 1. **C.R.S. 1963:** § 72-36-3. **L. 76:** (2) amended, p. 381, § 2, effective April 6. **L. 87:** (1)(a)(II) amended, p. 436, § 2, effective May 22. **L. 91:** (2) amended, p. 1224, § 3, effective May 24. **L. 94:** Entire section repealed, p. 554, § 20, effective April 6.

10-6-105. Employee benefits - minimum coverages. (1) Any captive insurance company issuing employee benefits coverages, as approved by the commissioner, in its plan of operation shall provide the minimum mandated insurance coverages required of insurance companies in the state.

(2) (a) (Deleted by amendment, L. 91, p. 1224, § 4, effective May 24, 1991.)

(b) (Deleted by amendment, L. 94, p. 542, § 3, effective April 6, 1994.)

Source: L. 72: p. 430, § 1. **C.R.S. 1963:** § 72-36-5. **L. 76:** (1) and (2)(a) amended, p. 381, § 3, effective April 6. **L. 87:** (2) amended, p. 436, § 3, effective May 22. **L. 89:** (1) amended, p. 463, § 3, effective April 15. **L. 91:** Entire section amended, p. 1224, § 4, effective May 24. **L. 94:** Entire section amended, p. 542, § 3, effective April 6.

10-6-106. Names of companies. No captive insurance company shall adopt the name of any existing company nor any name which may be misleading to the public.

Source: L. 72: p. 430, § 1. **C.R.S. 1963:** § 72-36-6. **L. 94:** Entire section amended, p. 543, § 4, effective April 6.

10-6-107. Formation and operation of captive insurance companies. (1) No person shall engage in the business of insurance as a captive insurance company without first applying for and obtaining a certificate of authority from the commissioner stating that such person complies with the laws of this state. Applicants shall submit articles of incorporation or other

documents of organization for examination. If accepted and approved by the commissioner and the attorney general, said articles or other documents of organization shall be filed in the office of the secretary of state. A copy of said articles or other documents of organization, certified by the secretary of state, shall be filed with the commissioner. Amendments to organizational documents shall be filed with the commissioner and in the office of the secretary of state.

(2) (Deleted by amendment, L. 94, p. 543, § 5, effective April 6, 1994.)

(3) Applicants for a captive insurance company certificate of authority shall file a detailed plan of operation, which shall include a feasibility study and any other information deemed relevant by the commissioner in ascertaining whether the proposed captive insurance company will be able to meet its policy obligations. The commissioner is authorized to refuse to issue a certificate of authority until the commissioner is reasonably satisfied that the plan of operation contains sufficient indication of a successful insurance operation.

(4) (a) Each captive insurance company shall pay to the division of insurance a nonrefundable application fee of five hundred dollars in addition to any reasonable expenses to be paid pursuant to section 10-6-120. Each captive insurance company shall pay an annual license fee of five hundred dollars.

(b) Notwithstanding the amount specified for any fee in paragraph (a) of this subsection (4), the commissioner by rule or as otherwise provided by law may reduce the amount of one or more of the fees if necessary pursuant to section 24-75-402 (3), C.R.S., to reduce the uncommitted reserves of the fund to which all or any portion of one or more of the fees is credited. After the uncommitted reserves of the fund are sufficiently reduced, the commissioner by rule or as otherwise provided by law may increase the amount of one or more of the fees as provided in section 24-75-402 (4), C.R.S.

(5) The principal and home office of every captive insurance company incorporated under this article shall be in the state of Colorado. Every captive insurance company shall maintain such books and records in this state as will enable the financial examination of the company by the commissioner.

(6) Group captive insurance companies shall limit their exposure to loss on any one risk or hazard to an amount not to exceed ten percent of capital and surplus, unless such risk or hazard is reinsured through an insurance company which is licensed or accredited in this state, or unless other safeguards to its financial solvency and stability are in place and are acceptable to the commissioner.

Source: L. 72: p. 430, § 1. **C.R.S. 1963:** § 72-36-7. **L. 89:** (1) to (3) amended, p. 463, § 4, effective April 15. **L. 94:** Entire section amended, p. 543, § 5, effective April 6. **L. 98:** (4) amended, p. 1327, § 30, effective June 1.

10-6-108. Control of operations. The business of each captive insurance company shall be managed by a board of directors or other governing body consisting of not less than three persons. The organizational documents or bylaws shall provide for the terms, meetings, and elections of the directors and officers of the governing body. No individual may serve as a director or officer who has been convicted of fraud involving any financial institution or of a felony involving misuse of funds.

Source: L. 72: p. 431, § 1. **C.R.S. 1963:** § 72-36-8. **L. 89:** (1) amended, p. 464, § 5, effective April 15. **L. 94:** Entire section R&RE, p. 545, § 6, effective April 6.

10-6-109. Increase of capital. (Repealed)

Source: L. 72: p. 432, § 1. **C.R.S. 1963:** § 72-36-9. **L. 94:** Entire section repealed, p. 554, § 20, effective April 6.

10-6-110. Violations - penalty. (Repealed)

Source: L. 72: p. 432, § 1. **C.R.S. 1963:** § 72-36-10. **L. 94:** Entire section repealed, p. 554, §20, effective April 6.

10-6-111. No seal required on policies. (Repealed)

Source: L. 72: p. 432, § 1. **C.R.S. 1963:** § 72-36-11. **L. 89:** Entire section amended, p. 464, § 6, effective April 15. **L. 94:** Entire section repealed, p. 554, § 20, effective April 6.

10-6-112. Deemed incorporated under corporation law. (Repealed)

Source: L. 72: p. 432, § 1. **C.R.S. 1963:** § 72-36-12. **L. 89:** Entire section amended, p. 464, § 7, effective April 15. **L. 94:** Entire section repealed, p. 554, § 20, effective April 6.

10-6-113. Authority to do business. (1) The certificate of authority issued to a captive insurance company shall expire on June 30 each year and shall be renewed annually, upon payment of all required fees and filing of all lawfully required reports, if the company has continued to comply with the laws of this state.

(2) Within thirty business days from the day the division of insurance receives a complete filing, the division shall render a decision on the application.

Source: L. 72: p. 432, § 1. **C.R.S. 1963:** § 72-36-13. **L. 76:** (2) amended, p. 381, § 4, effective April 6. **L. 87:** (2) amended, p. 437, § 4, effective May 22. **L. 91:** (2) amended, p. 1225, § 5, effective May 24. **L. 92:** (1) amended, p. 1562, § 69, effective July 1. **L. 94:** Entire section amended, p. 545, § 7, effective April 6.

10-6-114. Reports and statements. (1) Every captive insurance company doing business in this state shall render to the commissioner a report, signed and sworn to by its chief officers, of its condition as of the end of each fiscal year, which shall be in a form prescribed by the commissioner and contain such information as the commissioner deems necessary. Such report shall be filed within sixty days following the company's fiscal year end. The fiscal year shall be the calendar year for all group captive insurance companies. The commissioner may require that the annual report include the information set forth in the then-current convention blank of the national association of insurance commissioners, including any instructions, procedures, and guidelines consistent with this article.

(2) The commissioner may prescribe the format and frequency of other reports to be filed, which may include, but shall not be limited to, summary loss reports, quarterly financial statements, audited annual financial statements, and other professional reports.

(3) (Deleted by amendment, L. 94, p. 545, § 8, effective April 6, 1994.)

Source: L. 72: p. 433, § 1. **C.R.S. 1963:** § 72-36-14. **L. 89:** Entire section amended, p. 464, § 8, effective April 15. **L. 94:** Entire section amended, p. 545, § 8, effective April 6.

10-6-115. Grounds and procedure for suspension or revocation of certificate - review by commissioner. (1) The certificate of authority of a captive insurance company to do business in this state may be revoked or suspended by the commissioner for any violation of this article, including without limitation the following:

(a) Insolvency or impairment;

(b) Failure to meet the requirements of section 10-6-116;

(c) Refusal or failure to submit an annual report, as required by section 10-6-114, or any other report required by law or by lawful order of the commissioner;

(d) Failure to comply with the provisions of its own charter, other organizational documents, bylaws, or approved plan of operation, if such failure renders its operation hazardous to the public or to its policyholders;

(e) Failure to submit to examination;

(f) Refusal or failure to pay the cost of examination, required premium taxes, or other penalty or fee assessed as authorized by law;

(g) Use of methods which, although not otherwise specifically proscribed by law, render its operation hazardous or its condition unsound;

(h) Refusal or failure otherwise to comply with this article or any other laws of this state.

(2) If the commissioner finds upon examination, hearing, or other evidence that any captive insurance company has committed any of the acts specified in subsection (1) of this section, the commissioner may, after notice and hearing in accordance with article 4 of title 24, C.R.S., suspend or revoke such certificate of authority. The commissioner may issue an order appointing a supervisor to monitor the operations of the company if the commissioner deems it in the best interest of the public or of the policyholders of the company. The commissioner may commence a delinquency action pursuant to part 4 of article 3 of this title or a liquidation or rehabilitation action pursuant to part 5 of article 3 of this title.

(3) Any final decision of the commissioner on any matter pursuant to this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 72: p. 433, § 1. **C.R.S. 1963:** § 72-36-15. **L. 89:** (1)(d) amended, p. 465, § 9, effective April 15. **L. 92:** (2) amended, p. 1562, § 70, effective May 20. **L. 94:** Entire section amended, p. 546, § 9, effective April 6.

10-6-116. Capital and surplus requirements. (1) No captive insurance company issued a certificate of authority shall be permitted to do any business in this state unless it maintains total capital and surplus of not less than five hundred thousand dollars.

(1.5) Upon a written finding by the commissioner that the approved plan of operation or the operational results of the captive insurance company require either additional capital or a

larger surplus than required by this section, the commissioner may require that additional capital or surplus, or both, be obtained. Additional capital or surplus may be tendered in the form of an irrevocable letter of credit as set forth in subsection (2) of this section.

(2) Securities acceptable to the commissioner in the amount of three hundred thousand dollars, or such greater amount as determined by the commissioner, shall be held by the commissioner or under the joint control of the commissioner and the captive insurance company. The commissioner shall accept an irrevocable letter of credit, in a form acceptable to the commissioner, issued or confirmed by a qualified United States financial institution as defined in section 10-1-102 (17) on behalf of a captive insurance company in lieu of securities. All securities or letters of credit jointly held shall be the sole property of such captive insurance company and shall be free and clear of any claim or encumbrance.

(3) Jointly held securities or letters of credit, wherever located, shall be deemed to be held for the benefit of all captive insurance company policyholders.

(4) The commissioner shall release funds held under joint control upon a showing satisfactory to the commissioner that all debts, obligations, and liabilities of the captive insurance company have been paid and discharged, or adequate provisions for payment and discharge have been made therefor, and the captive insurance company's original certificate of authority has been returned to the commissioner.

Source: L. 72: p. 434, § 1. **C.R.S. 1963:** § 72-36-16. **L. 87:** (1) amended, p. 437, § 5, effective May 22. **L. 89:** (2) amended, p. 465, § 10, effective April 15. **L. 92:** (2) amended, p. 1562, § 71, effective May 20. **L. 94:** Entire section amended, p. 547, § 10, effective April 6. **L. 2003:** (2) amended, p. 617, § 15, effective July 1.

10-6-117. Security deposits - certificates. (Repealed)

Source: L. 72: p. 434, § 1. **C.R.S. 1963:** § 72-36-17. **L. 94:** Entire section repealed, p. 554, § 20, effective April 6.

10-6-118. Deposit and safekeeping of securities and letters of credit. (Repealed)

Source: L. 72: p. 434, § 1. **C.R.S. 1963:** § 72-36-18. **L. 92:** Entire section amended, p. 1563, § 72, effective May 20. **L. 94:** Entire section repealed, p. 554, § 20, effective April 6.

10-6-119. Surplus - letter of credit. (Repealed)

Source: L. 72: p. 435, § 1. **C.R.S. 1963:** § 72-36-19. **L. 87:** Entire section amended, p. 437, § 6, effective May 22. **L. 92:** (1) amended, p. 1563, § 73, effective May 20. **L. 94:** Entire section repealed, p. 554, § 20, effective April 6.

10-6-120. Examinations and investigations. (1) The commissioner or any person so authorized has the authority to examine the financial condition, affairs, and management of any applicant or captive insurance company operating under the laws of this state. For such purpose the commissioner shall have free access to all the books, papers, and documents relating to the business of the company, and the commissioner may summon witnesses and administer oaths

and affirmations in the examination of the directors, trustees, officers, agents, or employees of such company and any other person in relation to its affairs, transactions, and conditions. The reasonable cost of examinations of captive insurance companies shall be paid by the company examined and shall include the expenses of the commissioner and the commissioner's assistants.

(2) The commissioner may use other independent professionals, such as qualified actuaries, risk managers, certified public accountants, or examiners of insurance companies. The commissioner may also accept, as a part of the examination, reports or portions thereof made by the persons specified in this subsection (2). All reasonable expenses and charges of such persons so retained shall be paid directly by the captive insurance company being examined.

Source: L. 72: p. 435, § 1. **C.R.S. 1963:** § 72-36-20. **L. 89:** (7) added, p. 465, § 11, effective April 15. **L. 91:** (7) amended, p. 1248, § 11, effective July 1. **L. 94:** Entire section R&RE, p. 548, § 11, effective April 6.

10-6-121. Legal investments. (1) Group captive insurance companies shall comply with the investment requirements and limitations applicable to other insurance companies under the laws of this state as described in sections 10-1-102 (2) and (16), 10-3-213 to 10-3-242, and 10-3-802.

(2) (a) Pure captive insurance companies shall not be subject to any restrictions on investments whatsoever; except that the commissioner may prohibit or limit any investment that threatens the solvency or liquidity of any such company or if such investments are not made in accordance with the approved plan of operation.

(b) A pure captive insurance company may make loans to its parent company if approved within its plan of operations.

(3) In lieu of a fidelity bond, the officers, directors, or managers of a captive insurance company shall demonstrate sufficient safeguards to protect the funds of the captive insurance company.

Source: L. 72: p. 436, § 1. **C.R.S. 1963:** § 72-36-21. **L. 87:** Entire section amended, p. 438, § 7, effective May 22. **L. 89:** (2) amended and (3) to (11) added, p. 466, § 12, effective April 15. **L. 91:** IP(10) amended, p. 1225, § 6, effective May 24. **L. 94:** Entire section R&RE, p. 549, § 12, effective April 6. **L. 2003:** (1) amended, p. 617, § 16, effective July 1.

Cross references: For the regulation of the financial affairs of insurance companies, see part 2 of article 3 of this title 10.

10-6-122. Reinsurance. (1) Except as otherwise provided in subsection (2) of this section, any captive insurance company authorized to do business in this state may take credit for reserves on risks ceded to a reinsurer pursuant to part 7 of article 3 of this title and any applicable rules.

(2) Notwithstanding the provisions of subsection (1) of this section, any captive insurance company may cede risks to a reinsurer not meeting the standards of said subsection (1) and may take reserve credits if the captive insurance company receives prior written approval from the commissioner.

Source: L. 72: p. 436, § 1. **C.R.S. 1963:** § 72-36-22. **L. 94:** Entire section R&RE, p. 549, § 13, effective April 6. **L. 2014:** (1) amended, (HB 14-1315), ch. 295, p. 1218, § 6, effective January 1, 2015.

Cross references: For reinsurance generally, see § 10-3-701.

10-6-123. Filing of policy provisions - no requirement of filing for pure captive insurance companies. (Repealed)

Source: L. 72: p. 437, § 1. **C.R.S. 1963:** § 72-36-23. **L. 87:** (1) amended and (2) and (3) repealed, pp. 438, 439, §§ 8, 10, effective May 22. **L. 89:** (4) added, p. 467, § 13, effective April 15. **L. 94:** Entire section repealed, p. 554, § 20, effective April 6.

10-6-124. Making of rates. (Repealed)

Source: L. 72: p. 437, § 1. **C.R.S. 1963:** § 72-36-24. **L. 87:** Entire section repealed, p. 439, § 10, effective May 22.

10-6-125. Filing of rates. (1) A group captive insurance company's rates, rate classification systems, or funding levels shall be sufficient to fund expected operations and expenses. The commissioner may require that a pure captive insurance company file rating or funding data if such pure captive insurance company provides or plans to provide employee benefits.

(2) Rating structures for insurance applied to and paid by employees of a captive insurance company shall not be excessive, inadequate, or unfairly discriminatory.

Source: L. 72: p. 437, § 1. **C.R.S. 1963:** § 72-36-25. **L. 79:** (3) amended, p. 377, § 13, effective July 1. **L. 87:** (1) amended, p. 438, § 9, effective May 22. **L. 89:** (4) added, p. 467, § 14, effective April 15. **L. 94:** Entire section amended, p. 549, § 14, effective April 6.

10-6-126. Rating organizations - membership. (Repealed)

Source: L. 72: p. 437, § 1. **C.R.S. 1963:** § 72-36-26. **L. 94:** Entire section repealed, p. 554, § 20, effective April 6.

10-6-127. Guaranty fund coverage - not required. (1) Any provision of the law to the contrary notwithstanding, no captive insurance company shall be compelled to join or contribute financially to any plan, pool, association, or guaranty or insolvency fund in this state; nor shall any captive insurance company or its insured receive any benefit from such plan, pool, association, or guaranty or insolvency fund for claims arising out of operations of such captive insurance company.

(2) All policy forms or other evidence of coverage shall clearly disclose that guaranty fund coverage is not available.

Source: L. 72: p. 437, § 1. **C.R.S. 1963:** § 72-36-27. **L. 94:** Entire section amended, p. 550, § 15, effective April 6.

10-6-128. Tax on premiums collected - exemptions - penalties. (1) All captive insurance companies doing business in this state, except a disqualified insurance company, shall pay to the division of insurance an annual tax on the gross amount of all premiums collected, less premiums or premium credits returned to policyholders, on policies or contracts of insurance covering property or risks in this state and on risks and property situated in any other state in which the insurer has not paid premium tax.

(2) The tax imposed by subsection (1) of this section shall be the greater of:

(a) Five thousand dollars; or

(b) (I) One-half of one percent of the first twenty-five million dollars, plus one-quarter of one percent of the next fifty million dollars, plus one-tenth of one percent of each dollar thereafter of direct premiums collected, of the captive insurance company, plus:

(II) One-quarter of one percent of the first twenty million dollars, plus one-tenth of one percent of each dollar thereafter of assumed reinsurance premiums.

(c) and (d) (Deleted by amendment, L. 94, p. 550, § 16, effective April 6, 1994.)

(e) Premium tax shall not be payable in connection with the receipt of assets in exchange for the assumption of existing loss reserves and other liabilities.

(2.5) The minimum tax provided for in paragraph (a) of subsection (2) of this section shall be due and payable on the first day of March of each fiscal year, accompanied by such forms as may be prescribed by the commissioner. The balance of the tax when payable for each fiscal year shall be paid on forms prescribed by the commissioner together with the report required under section 10-6-114 (1). The commissioner may by rule require partial payments, to be made in quarterly installments, of the balance of the tax payable.

(3) The taxes provided for in this section shall constitute all taxes collectible under the laws of this state against any such captive insurance companies, and no other occupation tax or other taxes shall be levied or collected from any captive insurance company by the state or any county, city, or town within this state, except ad valorem taxes on real and personal property used in the production of income.

(4) to (8) (Deleted by amendment, L. 94, p. 550, § 16, effective April 6, 1994.)

Source: L. 72: p. 438, § 1. **C.R.S. 1963:** § 72-36-28. **L. 91:** (1) and (2) amended, p. 1225, § 7, effective January 1, 1992. **L. 94:** Entire section amended, p. 550, § 16, effective April 6. **L. 2021:** (1) amended, (HB 21-1311), ch. 298, p. 1786, § 13, effective June 23.

Cross references: For the legislative declaration in HB 21-1311, see section 1 of chapter 298, Session Laws of Colorado 2021.

10-6-128.5. Penalties. (1) The commissioner may charge a late fee of up to one hundred dollars per day for any required or reasonably requested report which is received after the filing deadline.

(2) Any company failing to pay taxes as specified in this article shall be liable to pay a penalty of up to one hundred dollars for each day of delinquency. If the tax paid is less than the full amount prescribed by this article, interest at the rate of one percent per month or fraction

thereof on the unpaid amount shall be charged from the date payment was due until the date full payment is received, and a penalty of up to twenty-five percent of the unpaid amount may be assessed. The amount of taxes and the penalties collected shall be transmitted to the state treasurer and credited to the general fund.

(3) The assessment of any fee or penalty against a captive insurance company shall be subject to the company's right to request a hearing and to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

(4) Any director, trustee, officer, agent, or employee of a captive insurance company or any other person who knowingly or willfully makes any materially false certificate, entry, or memorandum upon any of the books or papers of any captive insurance company or upon any statement filed or offered to be filed in the division of insurance or used in the course of any examination, inquiry, or investigation with the intent to deceive the commissioner or any person appointed by the commissioner to make such examination commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.

Source: L. 94: Entire section added, p. 553, § 17, effective April 6. **L. 2002:** (4) amended, p. 1468, § 27, effective October 1.

Cross references: For the legislative declaration contained in the 2002 act amending subsection (4), see section 1 of chapter 318, Session Laws of Colorado 2002.

10-6-129. Rules of commissioner. The commissioner may establish and from time to time amend such reasonable rules as are necessary to enable the commissioner to carry out the commissioner's duties under this article, including rules concerning the establishment and nature of loss reserves.

Source: L. 72: p. 439, § 1. **C.R.S. 1963:** § 72-36-29. **L. 92:** Entire section amended, p. 1564, § 74, effective May 20. **L. 94:** Entire section amended, p. 553, § 18, effective April 6.

10-6-130. Laws applicable. (1) The provisions of law generally applicable to insurance companies shall not apply to captive insurance companies except as specifically provided in this article and except that captive insurance companies are subject to parts 9 and 10 of article 2 of this title and parts 7, 11, and 12 of article 3 of this title.

(2) Group captive insurance companies are subject to the provisions of section 10-3-208 (3) to (7), part 2 of article 1 of this title, article 2 of this title, and parts 8 and 14 of article 3 of this title.

(3) The malpractice reporting requirements of sections 10-1-120 to 10-1-125 shall apply to captive insurance companies.

Source: L. 72: p. 439, § 1. **C.R.S. 1963:** § 72-36-30. **L. 89:** Entire section amended, p. 468, § 15, effective April 15. **L. 91:** Entire section amended, p. 1226, § 8, effective May 24. **L. 94:** Entire section amended, p. 554, § 19, effective April 6. **L. 97:** (2) amended, p. 92, § 2, effective March 24. **L. 2003:** (3) amended, p. 618, § 17, effective July 1.

LIFE INSURANCE

ARTICLE 7

Life Insurance

PART 1

GENERAL

10-7-101. Valuation of life policies. (1) As soon as practicable after the filing of the annual statement, the reserves for all outstanding policies of all life insurance companies making such statements shall be ascertained as provided in this section.

(2) (a) The commissioner shall ascertain the reserve for every policy in force on the books of domestic companies on the thirty-first day of December immediately preceding, in accordance with the following minimum standards:

(I) With respect to policies issued prior to March 28, 1945, the American experience table of mortality and four percent interest or the actuaries' combined experience table of mortality and four percent interest, as adopted by the company, with the privilege of one year preliminary term in either case; but, if any such company has any such policies outstanding issued on the basis of a higher reserve standard than the above, such higher standard shall be the minimum standard for such policies;

(II) With respect to policies issued after March 28, 1945, the American experience table of mortality and three and one-half percent interest, or the commissioner's 1941 standard ordinary mortality table and three and one-half percent interest, or, for industrial policies, the 1941 standard industrial mortality table and three and one-half percent interest, as adopted by the company, with the privilege of one year preliminary term in any case. For policies issued on a substandard basis, such other table of mortality as may be specified by the company and approved by the commissioner may be used. The mortality table and rate of interest prescribed in any of such policies as the basis for calculating nonforfeiture benefits thereunder, with the privilege of one year preliminary term, shall be used as the minimum standard for the valuation of such policies in case that standard produces greater aggregate reserves for all such policies than the standards above specified in this subparagraph (II).

(III) With respect to policies issued on or after the operative date of the "Standard Nonforfeiture and Valuation Act", part 3 of this article, and prior to the operative date of the valuation manual, in accordance with sections 10-7-309 to 10-7-313.2;

(IV) With respect to policies, including accident and health contracts and deposit-type contracts, issued on or after the operative date of the valuation manual, in accordance with sections 10-7-313.3 and 10-7-313.4.

(b) The commissioner may accept the valuation made by the company, upon satisfactory proof of its correctness.

(3) The reserve for all policies in force in any such domestic company being ascertained, as provided in this section, within sixty days thereafter, the company, at its option, may deposit with the commissioner for security and benefit of its policyholders the amount of the ascertained valuation in admitted assets which under section 10-3-235 (2) are securities eligible for optional reserve deposits. All companies depositing sufficient reserves as provided in this section may

print on their policies a certificate reading as follows: "The full reserve on this policy is deposited with the insurance commissioner in approved securities in accordance with the optional reserve deposit law of the state of Colorado".

(4) In valuing policies issued by foreign companies, the respective standard adopted by each company for such policies shall be used as the basis of the valuation, but the standard must not be lower than the standard prescribed by subsection (2) of this section for domestic companies.

(5) Reserves for all policies may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves than the minimum reserves required by this section.

(6) Valuation in the case of an alien company shall be limited to its United States business.

Source: L. 13: p. 349, § 41. **L. 15:** p. 271, § 1. **C.L.** § 2514. **CSA:** C. 87, § 54. **L. 45:** p. 413, § 1. **CRS 53:** § 72-3-1. **L. 61:** p. 465, § 9. **C.R.S. 1963:** § 72-3-1. **L. 65:** p. 765, § 1. **L. 69:** p. 500, § 6. **L. 2015:** (2)(a)(III) and (4) amended and (2)(a)(IV) added, (HB 15-1048), ch. 63, p. 152, § 1, effective August 5.

Cross references: For the operative date of the "Standard Nonforfeiture and Valuation Act", see § 10-7-315; for required financial statements, see § 10-3-208.

10-7-102. Life insurance policies - requirements. (1) It is unlawful for any foreign or domestic life insurance company to issue or deliver in this state any life insurance policy unless the policy contains the following provisions:

(a) A provision that all premiums shall be payable in advance, either at the home office of the company or to an agent of the company, upon delivery of a receipt signed by one or more of the duly authorized officers, unless the first payment is set forth in the policy, in which case the policy itself shall be a receipt;

(b) A provision that the policy shall constitute the entire contract between the parties and shall be incontestable after it has been in force during the lifetime of the insured for two years from its date, except for nonpayment of premiums and except for violation of the conditions of the policy relating to naval and military service in time of war or other prohibited risks, and, at the option of the company, provisions relative to benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident may also be excepted;

(c) A provision that no statement made by the insured shall avoid the policy unless it is contained in a written application and a copy of such application is endorsed upon or attached to the policy when issued;

(d) A provision that, if the age of the insured is misstated, the amount payable under the policy shall be such as the premium would have purchased at the correct age;

(e) A provision which fulfills the requirements of section 10-3-205. This provision shall not be required in nonparticipating policies.

(f) As to any policy issued prior to the operative date of the "Standard Nonforfeiture and Valuation Act", a provision fulfilling the requirements of section 10-7-107; except that such provision is not required in term insurance of twenty years or less; as to any policy issued on or

after the operative date of the "Standard Nonforfeiture and Valuation Act", provisions which fulfill the provisions of sections 10-7-302 to 10-7-307;

(g) A table showing in figures the loan values, if any, and the options available under the policies each year upon default in premium payments, during at least the first twenty years of the policy or during the life of the policy, if less than twenty years, beginning with the year in which such values and options become available;

(h) A table showing the amounts of installments in which the policy provides its proceeds are payable;

(i) A provision for a grace of one month, not less than thirty days, for the payment of every premium after the first year which is subject to an interest charge, during which month the insurance shall continue in force; but if the insured dies within the month of grace, the unpaid premium for the current policy year may be deducted in any settlement under the policy;

(j) If a policy is advertised or marketed as a means of payment of final expenses for final disposition or funeral merchandise or services other than according to the provisions of article 15 of this title 10, the policy must state in predominate type:

THIS POLICY DOES NOT GUARANTEE THAT ITS PROCEEDS WILL BE SUFFICIENT TO PAY FOR ANY PARTICULAR SERVICES OR MERCHANDISE AT TIME OF NEED OR THAT SERVICES OR MERCHANDISE SHALL BE PROVIDED BY ANY PARTICULAR PROVIDER.

(2) Any of the provisions of subsection (1) of this section or portions thereof relating to premiums not applicable to single premium policies shall to that extent not be incorporated therein.

Source: L. 13: p. 350, § 43. **C.L.** § 2516. **L. 27:** p. 449, § 1. **CSA:** C. 87, § 57. **CRS 53:** § 72-3-4. **L. 61:** p. 465, § 10. **C.R.S. 1963:** § 72-3-4. **L. 95:** (1)(j) added, p. 1046, § 2, effective May 25. **L. 2021:** IP(1) and (1)(j) amended, (SB 21-006), ch. 123, p. 489, § 4, effective September 7.

Cross references: For the operative date of the "Standard Nonforfeiture and Valuation Act", see § 10-7-315.

10-7-103. Life insurance policies - prohibition. (1) It is unlawful for any foreign or domestic life insurance company to issue or deliver in this state any life insurance policy if it contains any of the following provisions:

(a) A provision for forfeiture of the policy for failure to repay any loan on the policy, or to pay interest on such loan while the total indebtedness on the policy is less than the loan value thereof, or any provision for forfeiture for failure to repay any such loan or to pay interest thereon, unless such provision contains a stipulation that no such forfeiture shall occur until at least one month after notice has been mailed by the company to the last-known address of the insured and of the assignee, if any;

(b) A provision limiting the time within which any action may be commenced to less than five years after the cause of action accrues;

(c) A provision by which the policy purports to be issued or to take effect more than one year before the original application for the insurance was made, if thereby the assured would rate

at an age not more than one year younger than his age at date when application was made, according to his age at nearest birthday.

(2) A life insurance company doing business in Colorado may not refuse to insure, refuse to continue to insure, limit the amount or extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely for reasons associated with an applicant's or insured's past or future lawful foreign travel. Nothing in this subsection (2) shall prohibit a life insurer from excluding or limiting coverage of specific lawful travel, or charging a differential rate for such coverage, when bona fide differences in risk or exposure have been substantiated by the use of relevant data from at least one independent reliable source, including statistical or other mathematical analysis of available data that establishes a material variation in actual or reasonably anticipated experience that correlates to the risk of specific lawful travel. Travel advisories issued by the United States department of state shall not qualify as the sole source of data for purposes of this subsection (2). Each insurer shall maintain the data and documents that support any such differences and shall make the data and documents available upon request by the commissioner.

(3) A life insurance company doing business in Colorado shall not deny or alter benefits otherwise available to an individual with a terminal disease based on the availability of medical aid-in-dying pursuant to article 48 of title 25.

Source: L. 13: p. 351, § 44. **C.L.** § 2517. **CSA:** C. 87, § 58. **CRS 53:** § 72-3-5. **C.R.S. 1963:** § 72-3-5. **L. 2006:** (2) added, p. 710, § 1, effective July 1. **L. 2024:** (3) added, (SB 24-068), ch. 406, p. 2798, § 19, effective August 7.

Cross references: For the effect of a declaration under the "Colorado Medical Treatment Decision Act" on life insurance contracts, see § 15-18-111.

10-7-104. Exceptions. The provisions of sections 10-7-102 and 10-7-103 shall not apply to annuities, industrial policies, or corporations or associations operating on the assessment or fraternal plan; except that the commissioner may review variable annuities to ensure that such products are offered, marketed, or sold to a market suitable for such product.

Source: L. 13: p. 352, § 45. **C.L.** § 2518. **CSA:** C. 87, § 59. **CRS 53:** § 72-3-6. **C.R.S. 1963:** § 72-3-6. **L. 2004:** Entire section amended, p. 520, § 9, effective July 1.

10-7-105. Violation. The certificate of authority of any foreign or domestic life insurance company violating any of the provisions of sections 10-7-102 and 10-7-103 shall be suspended by the commissioner and shall not be renewed until such company fully and completely conforms to the same. Such action by the commissioner is subject to review by any court of competent jurisdiction.

Source: L. 13: p. 352, § 46. **C.L.** § 2519. **CSA:** C. 87, § 60. **CRS 53:** § 72-3-7. **C.R.S. 1963:** § 72-3-7.

10-7-105.5. Lapse of life insurance policy - notice - affidavit of mailing or electronic transmission - legislative declaration. (1) The general assembly finds, determines, and

declares that it is beneficial to citizens of this state for life insurers, prior to the lapse of individual life insurance policies for nonpayment of premium, to provide written notice in a uniform manner to policy owners.

(2) A notice of lapse of an individual life insurance policy for nonpayment of premium is effective only if:

(a) The information is mailed along with the reason for the lapse by first-class United States mail to the last-known address of the policy owner at least twenty-five days before the effective date of lapse; or

(b) The information is transmitted along with the reason for the lapse by electronic mail, if the policy owner consents to receive information related to an individual life insurance policy in electronic form, to the last-known electronic mail address of the policy owner on file with the insurer at least twenty-five days before the effective date of lapse of the individual life insurance policy.

(3) The affidavit, executed under penalty of perjury, of any officer, clerk, or agent of the insurer or of anyone authorized to mail or electronically transmit notices required by subsection (2) of this section, constitutes proof of notice under this section.

(4) This section does not apply to individual life insurance policies upon which premiums are paid monthly or at more frequent intervals.

(5) The commissioner may adopt rules necessary for the administration of this section.

Source: L. 2014: Entire section added, (HB 14-1082), ch. 80, p. 320, § 1, effective January 1, 2015.

10-7-106. Exclusive right of insured in proceeds. Whenever, under the terms of any annuity or policy of life insurance, or under any written agreement supplemental thereto, issued by any insurance company, domestic or foreign, lawfully doing business in this state, the proceeds are retained by such company at maturity or otherwise, no person, other than the insured, entitled to any part of such proceeds or any installment of interest due or to become due thereon shall be permitted to commute, anticipate, encumber, alienate, or assign the same, or any part thereof, if such permission is expressly withheld by the terms of such policy or supplemental agreement; and, if such policy or supplemental agreement so provides, no payments of interest or of principal shall be in any way subject to such person's debts, contracts, or engagements nor to any judicial processes to levy upon or attach the same for payment thereof.

Source: L. 25: p. 310, § 1. **CSA:** C. 87, § 64. **CRS 53:** § 72-3-11. **C.R.S. 1963:** § 72-3-11.

10-7-107. Nonforfeiture benefits - applicability. (1) In the event of default in the payment of any premium due on any policy issued after March 28, 1945, except term or convertible term policies, if not less than three full years' premiums have been paid thereon, there shall be secured to the insured, without action on his part, as specified in the policy, either paid-up insurance or extended insurance. The net value applied to such paid-up insurance or extended insurance shall be at least equal to the amount which would constitute the then reserve on the policy, including dividend additions, if any, calculated, with the privilege of one year

preliminary term, upon the mortality table and rate of interest used in the policy as a basis for the calculation of such nonforfeiture benefits under the policy, less two and one-half percent of the amount insured by the policy and dividend additions, if any, or one-fifth of such reserve, and less any outstanding indebtedness to the company on the policy at time of default; but the mortality table and rate of interest used as a basis for the calculation of such nonforfeiture benefits shall be designated in the policy and shall be a mortality table and an interest rate acceptable for the valuation of such policy pursuant to section 10-7-101 (2).

(2) If the mortality table so designated in any such policy is other than the American experience table of mortality, a rate of mortality not more than one hundred thirty percent of the rate of mortality according to the table designated may be assumed in calculating any extended insurance, with accompanying pure endowment, if any, offered as a nonforfeiture benefit.

(3) There shall be secured to the insured the right to surrender the policy to the company at its home office within one month after date of default for the cash value otherwise available for paid-up insurance or extended insurance, but the right to cash dividends or to cash surrender value, provided by this section and section 10-3-205, may be specifically waived in the policy.

(4) Nothing in this section shall be construed to prohibit the company from including in its policies a provision for automatic premium loans to prevent premium default.

(5) No agreement between the company and the policyholder or applicant for insurance shall be held to waive any of the provisions of this section and section 10-3-205, except as provided in this section.

(6) Subsections (1) to (5) of this section shall not apply to any policy issued on or after the operative date of the "Standard Nonforfeiture and Valuation Act". As to any such policy the provisions of sections 10-7-302 to 10-7-308 shall be applicable.

Source: L. 13: p. 353, § 50. **C.L.** § 2523. **CSA:** C. 87, § 65. **L. 45:** p. 414, § 2. **CRS 53:** § 72-3-12. **L. 61:** p. 465, § 11. **C.R.S. 1963:** § 72-3-12.

Cross references: For the operative date of the "Standard Nonforfeiture and Valuation Act", see § 10-7-315.

10-7-108. Regulating vouchers for disbursements. No domestic life insurance company shall make any disbursement unless the same is evidenced by a voucher correctly describing the consideration for the payment. If the expenditure is for both services and disbursements, the voucher shall set forth the services rendered and an itemized statement of the disbursements made. If the expenditure is in connection with any matter pending before any legislative or public body, or before any department or officer of any state or government, the voucher shall correctly describe, in addition, the nature of the matter and of the interest of such company therein. When such voucher cannot be obtained, the expenditure shall be evidenced by an affidavit describing the character and object of the expenditure and stating the reason for not obtaining such voucher.

Source: L. 13: p. 354, § 51. **C.L.** § 2524. **CSA:** C. 87, § 66. **CRS 53:** § 72-3-13. **C.R.S. 1963:** § 72-3-13. **L. 71:** p. 717, § 1.

10-7-109. Suicide no defense for nonpayment. The suicide of a policyholder after the first policy year of any life insurance policy issued by any life insurance company doing business in this state shall not be a defense against the payment of a life insurance policy, whether said suicide was voluntary or involuntary, and whether said policyholder was sane or insane. Nothing in this section is intended or shall be construed to apply to any accident insurance policy insuring against accidental death or death by accidental means or to those parts or provisions of any life insurance policy insuring specifically against accidental death or death by accidental means.

Source: L. 13: p. 358, § 59. **C.L.** § 2532. **L. 35:** p. 573, § 1. **CSA:** C. 87, § 76. **CRS 53:** § 72-3-23. **C.R.S. 1963:** § 72-3-23.

10-7-110. Minor's capacity to contract for life insurance and annuities and to exercise rights concerning same. (Repealed)

Source: L. 65: p. 756, § 1. **C.R.S. 1963:** § 72-1-55. **L. 77:** Entire section repealed, p. 519, § 1, effective March 26.

10-7-111. Minor's capacity to give acquittances for insurance or annuity payments. (Repealed)

Source: L. 65: p. 757, § 2. **C.R.S. 1963:** § 72-1-56. **L. 77:** Entire section repealed, p. 519, § 1, effective March 26.

10-7-112. Interest payable on benefits or proceeds. (1) Notwithstanding any other provision of law, each insurer admitted to transact the business of life insurance in this state shall pay interest on the death benefits using an interest rate that is not less than the rate of interest for proceeds left on deposit with the insurer and subject to withdrawal on demand for the period beginning at the date of death through thirty days following the date of receipt by the insurer of a complete request for payout including due proof of death. From that date until the date of settlement of the claim, the annual rate of interest shall be two percentage points above the federal discount rate, which rate shall be the rate of interest a commercial bank pays to the federal reserve bank of Kansas City using a government bond or other eligible paper as security and shall be rounded to the nearest full percent. If the claim is denied and a judgment is rendered against the insurer, the annual rate of interest from the date the action was filed until payment of the claim shall be four percentage points above the federal discount rate, except to the extent such proceeds were deposited with the court in an interpleader action. Any other life insurance policy or contract benefits shall accrue interest at a rate of at least two percentage points above the federal discount rate when any such benefits are not paid more than thirty days after the date of receipt by an insurer of a complete request for payment from an insured. The rates referred to in this subsection (1) shall be determined using a weighted average of the rates in effect during the applicable period based upon the number of days the rate was in effect.

(2) This section shall not require the payment of interest in any case in which the beneficiary elects in writing, delivered to the insurer, to receive the proceeds of the policy by any means other than a lump sum payment thereof.

(3) Nothing in this section shall be construed to allow any insurer admitted to transact the business of life insurance in this state to withhold payment of benefits under a life insurance policy to any beneficiary for a period longer than reasonably necessary to make such payment.

(4) For the purposes of this section, the term "life insurance" shall include:

(a) All individual and group life insurance policies issued in accordance with the provisions of this article;

(b) Life insurance plans issued in connection with part 6 of article 50 of title 24, C.R.S.;

(c) Life insurance policies issued in accordance with the provisions of article 9 of this title;

(d) Life insurance policies or certificates issued in accordance with the provisions of article 10 of this title;

(e) Life insurance benefits payable under accident only type policies; and

(f) Life insurance policies or certificates issued by fraternal benefit societies licensed to do business in this state under article 14 of this title.

Source: L. 83: Entire section added, p. 459, § 1, effective July 1. **L. 92:** (1) amended, p. 1564, § 75, effective May 20. **L. 94:** (4)(b) amended, p. 1136, § 3, effective May 19. **L. 99:** (1) amended, p. 1006, § 1, effective August 4.

10-7-113. Acceleration of benefits. (1) Any policy of life or endowment insurance or annuity contract or contract supplemental thereto may contain benefits providing for the acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be payable for an insured:

(a) Who is diagnosed with a terminal case of AIDS, as defined in section 10-3-1104.5 (2)(a), or with any other terminal illness, for health-care expenses or for long-term care which is certified or ordered by a physician; or

(b) Upon the occurrence of a qualifying event, as defined by the policy or contract.

(2) For the purposes of this section, "long-term care" shall include but need not be limited to hospice care, adult day care, professional nursing care, medical care expenses, custodial nursing care, and nonnursing custodial care provided in a nursing home or at a residence of the insured.

(3) The commissioner may request filing, for information purposes, the premium rates or discount rates applied to an acceleration of life insurance or endowment or annuity benefits in advance of the time they would otherwise be payable for an insured.

Source: L. 89: Entire section added, p. 449, § 5, effective April 15. **L. 90:** Entire section amended, p. 621, § 1, effective March 22.

10-7-114. Actuarial opinion of reserves - definition - rules. (1) **Actuarial opinion prior to the operative date of the valuation manual.** Before the operative date of the valuation manual, as that term is defined in section 10-7-301.5 (7):

(a) Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with

applicable laws of this state. The commissioner by rule shall define the specifics of the opinion required by this subsection (1) and add any other items deemed to be necessary to its scope.

(b) The opinion must apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

(c) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as the commissioner may by rule prescribe.

(d) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(e) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person other than the insurance company and the commissioner for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(f) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the opinion, shall be kept confidential by the commissioner and shall not be made public and is not subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this subsection (1) or by rules promulgated pursuant to this subsection (1); except that the memorandum or other material may otherwise be released by the commissioner with the written consent of the company or, upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings, to the American Academy of Actuaries. The commissioner shall require that any request of this nature from the American Academy of Actuaries set forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of a confidential memorandum prepared for purposes of this subsection (1) is cited by an insurer in its marketing or is cited before any governmental agency other than a state insurance regulatory authority or is released by the insurer to any news media, the confidentiality of the portions of any confidential memorandum are deemed waived.

(g) Every life insurance company, except as exempted by or pursuant to rule, shall also annually include in the opinion required by this subsection (1) an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts including the benefits under and expenses associated with the policies and contracts. The commissioner may provide by rule for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this subsection (1).

(h) Each opinion required by paragraph (g) of this subsection (1) is subject to the following requirements:

(I) A memorandum, in form and substance acceptable to the commissioner as specified by rule, shall be prepared to support each actuarial opinion for each year on or after December 31, 1992.

(II) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule, or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by rule or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare any supporting memorandum required by the commissioner.

(1.1) **Definition.** For purposes of subsection (1) of this section, "qualified actuary" means a person who:

(a) Is a member in good standing of the American Academy of Actuaries, or is experienced, skilled, and competent to perform actuarial duties, and meets the requirements set forth by rule of the commissioner;

(b) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

(c) Is familiar with the valuation requirements applicable to life and health insurance companies;

(d) Has not been found by the commissioner, upon appropriate notice and hearing, or, if so found, has been reinstated as a qualified actuary, to have:

(I) Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as a qualified actuary;

(II) Been found guilty of fraudulent or dishonest practices;

(III) Demonstrated incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(IV) Submitted to the commissioner, during the past five years, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this part 1 and part 7 of this article including standards set by the Actuarial Standards Board or its successor; or

(V) Resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(e) Has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under paragraph (d) of subsection (1) of this section.

(2) **Actuarial opinion of reserves after the operative date of the valuation manual.** On and after the operative date of the valuation manual, as that term is defined in section 10-7-301.5 (7):

(a) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The valuation manual will prescribe the specifics of this opinion, including any item the commissioner deems to be necessary to its scope.

(b) Every opinion required by this subsection (2) is governed by the following provisions:

(I) The opinion must be in form and substance as specified in the valuation manual and acceptable to the commissioner.

(II) The opinion must be submitted with the annual statement reflecting the valuation of reserve liabilities for each year ending on or after the operative date of the valuation manual.

(III) The opinion must apply to all policies and contracts subject to this paragraph (b), plus other actuarial liabilities as may be specified in the valuation manual.

(IV) The opinion must be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual.

(V) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(VI) Except in cases of fraud or willful misconduct, the appointed actuary is not liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion.

(VII) Disciplinary actions capable of being taken by the commissioner against the company or the appointed actuary must be defined in rules promulgated by the commissioner.

(c) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by this subsection (2) an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under its policies and contracts, including the benefits under and expenses associated with the policies and contracts.

(d) Each opinion required by paragraph (c) of this subsection (2) is governed by the following provisions:

(I) A memorandum, in form and substance as specified in the valuation manual and acceptable to the commissioner, must be prepared to support each actuarial opinion.

(II) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual, or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

Source: L. 92: Entire section added, p. 1494, § 23, effective July 1. **L. 2015:** Entire section amended, (HB 15-1048), ch. 63, p. 153, § 2, effective August 5.

Editor's note: Subsection (1.1) is similar to former subsection (1)(e) as it existed prior to 2015.

10-7-115. Insurable interest - 170 (c) organizations. Notwithstanding any other provision of law, any organization that meets the requirements of section 170 (c) of the federal "Internal Revenue Code of 1986", as amended, may own or purchase life insurance on an insured who gives written consent to the ownership or purchase of that insurance. The provisions of this section do not limit or abridge any insurable interest or right to insure now existing at common law or by statute, shall be construed liberally to sustain the existence of an insurable interest, and shall stand as a declaration of existing law applicable to all life insurance policies whenever issued, in existence on or after March 20, 1992.

Source: L. 92: Entire section added, p. 1760, § 1, effective March 20.

Editor's note: This section was originally numbered as § 10-7-114 by House Bill 92-1031 but was renumbered on revision for ease of location.

10-7-116. Military sales - rules. The commissioner shall promulgate rules, consistent with federal law, to define dishonest, unfair, and deceptive marketing and sales practices to military personnel and their families. The rules shall not affect federal insurance programs under 38 U.S.C. sec. 1965 et seq.

Source: L. 2007: Entire section added, p. 1990, § 1, effective August 3.

PART 2

GROUP LIFE INSURANCE

10-7-201. Group life insurance. (1) No policy of group life insurance shall be delivered in this state unless:

(a) The policyholder was formed for purposes other than obtaining insurance, or is a trust established by one or more employers or by one or more labor unions, or by one or more employers and one or more labor unions; and

(b) (Deleted by amendment, L. 2010, (HB 10-1203), ch. 47, p. 177, § 1, effective March 29, 2010.)

(c) An individual eligible for coverage is subject to such uniformly applied standards of insurability as may be imposed by the insurer.

(d) Repealed.

(2) Insurance under any group life insurance policy may be extended to insure dependents.

(3) Repealed.

Source: L. 19: p. 441, § 1. **C.L.** § 2594. **L. 29:** p. 388, § 1. **CSA:** C. 87, § 164. **L. 47:** p. 580, § 1. **L. 53:** p. 373, §§ 1, 2. **CRS 53:** § 72-6-1. **L. 55:** p. 459, § 1. **L. 59:** p. 509, § 1. **C.R.S. 1963:** § 72-6-1. **L. 65:** p. 766, § 1. **L. 67:** pp. 164, 165, 174, 184, §§ 1-4, 1, 1. **L. 73:** p. 850, § 1. **L. 77:** (1)(f) amended, p. 520, § 1, effective May 14; entire section R&RE, p. 521, § 1, effective July 1. **L. 79:** (3) repealed, p. 393, § 1, effective May 25. **L. 83:** (1)(d) repealed, p. 463, § 2,

effective March 16. **L. 2010:** (1) amended, (HB 10-1203), ch. 47, p. 177, § 1, effective March 29.

Editor's note: Subsection (1)(f) was amended in House Bill 77-1232. Those amendments were superseded by the repeal and reenactment of the section in House Bill 77-1445.

10-7-202. Policy provisions. (1) No policy of group life insurance shall be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the commissioner are more favorable to the certificate owners, or at least as favorable to the certificate owners and more favorable to the policyholder; except that paragraphs (f) to (j) of this subsection (1) shall not apply to policies issued to a creditor to insure debtors of such creditor; that the standard provisions required for individual life insurance policies shall not apply to group life insurance policies; and that, if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision which in the opinion of the commissioner is equitable to the certificate owners and to the policyholder, but nothing in this section shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies:

(a) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

(b) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any person insured under the policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him;

(c) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the certificate owner, to his assignee, or to his beneficiary;

(d) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage;

(e) A provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured is misstated, such provision to contain a clear statement of the method of adjustment to be used;

(f) A provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the certificate owner, subject to the provisions of the policy and in the event there is no designated beneficiary as to all or any part of such sum living at the death of the person insured, and subject to any right reserved by the insurer in the

policy and set forth in the certificate to pay at its option a part of such sum not exceeding five thousand dollars to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred verifiable funeral expenses or other verifiable expenses when such expenses are incident to the last illness or death of the person insured;

(g) A provision that the insurer will issue to the policyholder for delivery to the certificate owner an individual certificate setting forth a statement as to the insurance protection provided, to whom the insurance benefits are payable, and the rights and conditions set forth in paragraphs (h), (i), and (j) of this subsection (1);

(h) A provision that, if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of membership in the class eligible for coverage under the policy, the certificate owner shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits; except that application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one days after such termination, and except that:

(I) The individual policy, at the option of the certificate owner, shall be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for;

(II) The individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination; except that any amount of insurance which has matured as an endowment, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

(III) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which the insured person then belongs, and to his age attained on the effective date of the individual policy;

(i) A provision that, if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, the owner of each certificate with respect to a person insured thereunder whose insurance terminates and who has been so insured for at least five years prior to such termination date shall be entitled to have issued to him by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by paragraph (h) of this subsection (1); except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one days after such termination, and two thousand dollars;

(j) A provision that, if a person insured under the group policy dies during the period within which the certificate owner would have been entitled to have an individual policy issued to him in accordance with paragraph (h) or (i) of this subsection (1) and before such an individual policy has become effective, the amount of life insurance which the certificate owner would have been entitled to have issued to him under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

(2) The provisions of paragraphs (h) to (j) of subsection (1) of this section shall apply to any insurance issued pursuant to section 10-7-201 on the life of a spouse of an employee or member.

Source: L. 19: p. 441, § 2. **C.L.** § 2595. **CSA:** C. 87, § 165. **L. 47:** p. 584, § 2. **CRS 53:** § 72-6-2. **C.R.S. 1963:** § 72-6-2. **L. 67:** p. 174, § 2. **L. 77:** (2) amended, p. 522, § 2, effective July 1. **L. 83:** IP(1), (1)(c), and (1)(f) to (1)(j) amended, p. 461, § 1, effective July 1. **L. 85:** (1)(f) amended, p. 386, § 1, effective July 1.

10-7-203. Employer defined. The term "employer" as used in sections 10-7-201 and 10-7-202 includes counties, cities, cities and counties, incorporated towns, school districts, and other political subdivisions of this state; and such subdivisions, in order to promote the better efficiency of its employees, may insure its employees, or any class thereof, under a policy of group insurance covering life, health, or accident insurance for such employees and may pay, or authorize to be paid, out of the corporate revenue of such political subdivisions the premiums required from time to time to maintain such group insurance in force; and, if such employees are required to contribute to the cost of their insurance, deductions for this purpose may be made from their salaries.

Source: L. 47: p. 587, § 3. **CSA:** C. 87, § 165 (1). **CRS 53:** § 72-6-3. **C.R.S. 1963:** § 72-6-3.

10-7-204. Reciprocal provisions. Policies of group insurance, when issued in this state by any company not organized under the laws of this state, may contain any provision required by the law of the state or territory or district of the United States under which the company is organized. Any group policy may be issued or delivered in this state which in the opinion of the commissioner contains provisions on any one or more of the several foregoing requirements more favorable to the employer or to the employee than required prior to April 4, 1919. Policies issued in other states or countries by companies organized in this state may contain any provision required by the laws of the state, territory, district, or country in which the same are issued, anything in this part 2 to the contrary notwithstanding.

Source: L. 19: p. 443, § 3. **C.L.** § 2596. **CSA:** C. 87, § 166. **CRS 53:** § 72-6-4. **C.R.S. 1963:** § 72-6-4.

10-7-205. Exemption from execution. No policy of group insurance, nor the proceeds thereof, when paid to any employee thereunder, shall be liable to attachment, garnishment, or other process, or be seized, taken, appropriated, or applied by any legal or equitable process or operation of law, to pay any debt or liability of such employee, or his beneficiary, or any other person who may have a right thereunder, either before or after payment, nor shall the proceeds thereof, where not made payable to a named beneficiary, constitute a part of the estate of the employee for the payment of his debts.

Source: L. 19: p. 443, § 4. **C.L.** § 2597. **CSA:** C. 87, § 167. **CRS 53:** § 72-6-5. **C.R.S. 1963:** § 72-6-5.

Cross references: For property and earnings exempt from execution, see article 54 of title 13.

10-7-206. Issuance and valuation of policies - annual statement. (1) Any life insurance company may issue life or endowment insurance, with or without annuities, upon the group plan, as defined in section 10-7-201, with special rates of premiums less than the usual rates of premiums for such policies. Group policies issued prior to the operative date of the "Standard Nonforfeiture and Valuation Act" may be valued on any accepted table of mortality and interest assumption adopted by the company for that purpose, but in no case shall the standard for any such policy be lower than the medico-actuarial table of mortality, or such other table of mortality as may be approved by the commissioner, with interest assumption at three and one-half percent. Group policies issued on or after the operative date of the "Standard Nonforfeiture and Valuation Act" shall be valued in accordance with the provisions of sections 10-7-309 to 10-7-313.

(2) All policies of group insurance shall be segregated by the company into separate classes, the mortality experience kept separate, and the number of policies, amount of insurance, reserves, premiums, and payments to the policyholders thereunder, together with the mortality table and interest assumption adopted by the company, shall be reported separately in the company's annual financial statement.

Source: L. 19: p. 444, § 5. **C.L.** § 2598. **CSA:** C. 87, § 168. **L. 45:** p. 416, § 3. **CRS 53:** § 72-6-6. **L. 61:** p. 465, § 12. **C.R.S. 1963:** § 72-6-6.

Cross references: For the operative date of the "Standard Nonforfeiture and Valuation Act", see § 10-7-315.

10-7-207. Assignment. Nothing in this title or in any other law shall be construed to prohibit any person insured under a group life insurance policy from making an assignment of all or any part of his incidents of ownership under such policy, including, but not limited to, the privilege to have issued to him an individual policy of life insurance pursuant and subject to the provisions of section 10-7-202 and the right to name a beneficiary. Subject to the terms of the policy or agreement between the insured, the group policyholder, and the insurer, relating to assignment of incidents of ownership thereunder, such an assignment by an insured is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all of such incidents of ownership so assigned, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue prior to receipt of notice of the assignment.

Source: L. 71: p. 721, § 1. **C.R.S. 1963:** § 72-6-7.

PART 3

STANDARD NONFORFEITURE AND VALUATION ACT

10-7-301. Short title. This part 3 shall be known and may be cited as the "Standard Nonforfeiture and Valuation Act".

Source: L. 61: p. 460, § 1. **CRS 53:** § 72-20-1. **C.R.S. 1963:** § 72-19-1.

10-7-301.5. Definitions. As used in this part 3, unless the context otherwise requires:

(1) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(2) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in section 10-7-114 (2).

(3) "Company" means an entity that:

(a) Has written, issued, or reinsured life insurance, accident and health insurance, or deposit-type contracts in this state and has at least one such policy in force or on claim; or

(b) Has written, issued, or reinsured life insurance, accident and health insurance, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state.

(4) "Deposit-type contract" means a contract that does not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(5) "Life insurance" means a contract that incorporates mortality risk, including annuity and pure endowment contracts and as may be specified in the valuation manual.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Operative date of the valuation manual" means the date described in section 10-7-313.3 (2).

(8) "Policyholder behavior" means any action a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this part 3 including lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(9) "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with section 10-7-313.4 as specified in the valuation manual.

(10) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(11) "Tail risk" means a risk that occurs either when the frequency of low probability events is higher than expected under a normal probability distribution or when there are observed events of very significant size or magnitude.

(12) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this part 3 or as subsequently amended.

Source: L. 2015: Entire section added, (HB 15-1048), ch. 63, p. 157, § 3, effective August 5.

10-7-302. Compulsory policy provisions. (1) On and after the operative date of this part 3, no policy of life insurance, except as stated in section 10-7-307, shall be delivered or issued for delivery in this state by any foreign or domestic life insurance company unless it contains in substance the following provisions or corresponding provisions which, upon findings of fact by the commissioner, are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this section, and are essentially in compliance with section 10-7-306.1:

(a) That, in the event of default in any premium payment after premiums have been paid for at least one full year, the company will grant, upon proper election and notice thereof to the company not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be specified in this part 3. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(b) That, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be specified in this part 3;

(c) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default;

(d) That, if the policy becomes paid-up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be specified in this part 3;

(e) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefits, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance laws of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by

the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy;

(g) A notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within fifteen days of its delivery and to have any premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason and, in the case of a variable life insurance policy, the amount refunded shall be the account value calculated as of the date the policy is returned plus any policy fee or charge deducted from the policy. Any refund made pursuant to this paragraph (g) shall be paid directly to the policyholder by the insurer in a timely manner.

(2) Any of the foregoing provisions or portions of this section not applicable by reason of the plan of insurance, to the extent inapplicable, may be omitted from the policy.

(3) The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

Source: L. 61: p. 460, § 2. **CRS 53:** § 72-20-2. **C.R.S. 1963:** § 72-19-2. **L. 77:** (1)(f) R&RE and (2) amended, p. 523, §§ 1, 2, effective July 1. **L. 81:** IP(1), (1)(a), and (1)(e) amended, p. 542, § 1, effective July 1. **L. 92:** (1)(g) added, p. 1564, § 76, effective May 20. **L. 99:** (1)(g) amended, p. 1007, § 2, effective August 4.

Cross references: For the operative date of this part 3, see § 10-7-315.

10-7-303. Computation of cash surrender value. (1) (a) Except as provided in paragraphs (b) and (c) of this subsection (1), any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by section 10-7-302, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(I) The then present value of the adjusted premiums, as defined in sections 10-7-305 and 10-7-305.1, corresponding to premiums which would have fallen due on and after such anniversary; and

(II) The amount of any indebtedness to the company on the policy.

(b) For any policy issued on or after the operative date of section 10-7-305.1 which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in paragraph (a) of this subsection (1) shall be an amount not less than the sum of the cash surrender value as defined in said paragraph (a) for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in said paragraph (a) for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

(c) For any family policy issued on or after the operative date of section 10-7-305.1 which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse reaches age seventy-one, the cash surrender value referred to in paragraph (a) of this subsection (1) shall be an amount not less than the sum of the cash surrender value as defined in said paragraph (a) for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in said paragraph (a) for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

(2) Any cash surrender value available within thirty days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by section 10-7-302, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

Source: L. 61: p. 461, § 3. **CRS 53:** § 72-20-3. **C.R.S. 1963:** § 72-19-3. **L. 81:** Entire section amended, p. 543, § 2, effective July 1.

10-7-304. Computation of nonforfeiture benefit. Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this part 3 in the absence of the condition that premiums shall be paid for at least a specified period.

Source: L. 61: p. 462, § 4. **CRS 53:** § 72-20-4. **C.R.S. 1963:** § 72-19-4.

10-7-305. Adjusted premiums. (1) This section shall not apply to policies issued on or after the operative date of section 10-7-305.1. Except as provided in subsection (3) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

(a) The then present value of the future guaranteed benefits provided for by the policy;

(b) Two percent of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount, as defined in subsection (2) of this section, if the amount of insurance varies with duration of the policy;

(c) Forty percent of the adjusted premium for the first policy year;

(d) Twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. In applying the percentages specified in paragraph (c) of this subsection (1) and this paragraph (d), no adjusted premium shall be deemed to exceed four percent of the

amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

(2) In the case of a policy providing an amount of insurance varying with the duration of the policy, the equivalent uniform amount thereof for the purpose of this section shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy; except that, in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by such policy at age ten.

(3) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision, unless such term insurance benefits are disregarded under section 10-7-306, shall be equal to: The adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by the adjusted premiums for such term insurance, the two latter premiums being calculated separately and as specified in subsections (1) and (2) of this section.

(4) Except as otherwise provided in subsection (5) of this section, all adjusted premiums and present values referred to in this part 3 shall be calculated on the basis of the commissioners 1958 standard ordinary mortality table for ordinary insurance and the 1941 standard industrial mortality table for industrial insurance; except that:

(a) For any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured;

(b) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, in the case of ordinary insurance, the rates of mortality assumed may be not more than those shown in the commissioners 1958 extended term insurance table, and, in the case of industrial insurance, the rates of mortality assumed may be not more than one hundred thirty percent of the rates of mortality according to the 1941 standard industrial mortality table;

(c) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner;

(d) All calculations shall be made on the basis of the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Such specified rate of interest shall not exceed three and one-half percent per annum; except that a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after July 1, 1977, and except that for any single-premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per annum may be used.

(5) (a) In the case of industrial policies issued on or after the operative date of this subsection (5), as defined in paragraph (b) of this subsection (5), all adjusted premiums and present values referred to in this part 3 shall be calculated on the basis of the commissioners 1961 standard industrial mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Such specified rate of

interest shall not exceed three and one-half percent per annum; except that a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after July 1, 1977, and except that for any single-premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per annum may be used. However, in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1961 industrial extended term insurance table and except that, for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(b) After April 9, 1965, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection (5) after a specified date but before January 1, 1968. After the filing of such notice, then, upon such specified date (which shall be the operative date of this subsection (5) for such company), this subsection (5) shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this subsection (5) for such company shall be January 1, 1968.

Source: L. 61: p. 462, § 5. **CRS 53:** § 72-20-5. **C.R.S. 1963:** § 72-19-5. **L. 65:** p. 770, § 1. **L. 77:** (4)(a), (4)(d), and (5)(a) amended, p. 524, § 3, effective July 1. **L. 81:** IP(1) amended, p. 544, § 3, effective July 1.

10-7-305.1. Adjusted premiums for new policies. (1) (a) This section shall apply to all policies issued on or after the operative date of this section. Except as provided in subsection (7) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of:

(I) The then present value of the future guaranteed benefits provided for by the policy;

(II) One percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(III) One hundred twenty-five percent of the nonforfeiture net level premium as specified in subsection (2) of this section.

(b) In applying the percentage specified in subparagraph (III) of paragraph (a) of this subsection (1), no nonforfeiture net level premium shall be deemed to exceed four percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present

value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(3) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in subsection (7) of this section, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of:

(a) The sum of the then present value of the then future guaranteed benefits provided for by the policy, and the additional expense allowance, if any; over

(b) The then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:

(a) One percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and

(b) One hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing the amount specified in paragraph (a) by the amount specified in paragraph (b) of this subsection (6) where:

(a) This paragraph (a) equals the sum of:

(I) The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(II) The present value of the increase in future guaranteed benefits provided for by the policy; and where

(b) This paragraph (b) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Notwithstanding any other provisions of this section to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(8) All adjusted premiums and present values referred to in this part 3 for all policies of ordinary insurance issued on or after the operative date of this section shall be calculated on the basis of the commissioners 1980 standard ordinary mortality table or, at the election of the company for any one or more specified plans of life insurance, on the basis of the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors; for all policies of industrial insurance issued on or after the operative date of this section shall be calculated on the basis of the commissioners 1961 standard industrial mortality table; and for all policies issued in a particular calendar year on or after the operative date shall be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section for policies issued in that calendar year, subject to the following:

(a) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year.

(b) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by section 10-7-302, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(c) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions under the policy, on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(d) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1980 extended term insurance table for policies of ordinary insurance and not more than the commissioners 1961 industrial extended term insurance table for policies of industrial insurance.

(e) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the tables specified in this subsection (8).

(f) (I) For policies issued prior to the operative date of the valuation manual, any commissioners standard ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the commissioners 1980 extended term insurance table.

(II) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the

commissioners 1980 extended term insurance table. If the commissioner approves by rule any commissioners standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(g) (I) For policies issued prior to the operative date of the valuation manual, any commissioners standard industrial mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by rule promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table.

(II) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table. If the commissioner approves by rule any commissioners standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(9) (a) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year must be equal to one hundred twenty-five percent of the calendar year statutory valuation interest rate for such policy as defined in this part 3, rounded to the nearer one-quarter of one percent; except that the nonforfeiture interest rate may not be less than four percent.

(b) For policies issued on or after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year must be as provided by the valuation manual.

(10) Notwithstanding any other provision in this article to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(11) On or after July 1, 1981, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1989, which specified date shall be the operative date of this section for such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1989.

Source: L. 81: Entire section added, p. 544, § 4, effective July 1. **L. 2015:** IP(8), (8)(f), (8)(g), and (9) amended, (HB 15-1048), ch. 63, p. 159, § 4, effective August 5.

Editor's note: "Commissioners Standard Ordinary Mortality Table" is an actuarial table used to compute the minimum nonforfeiture values of ordinary life insurance policies. The

Commissioners Standard Ordinary Mortality Table reflects the probability that people in various age groups will die in a given year.

10-7-305.2. Future premium determination - standards. (1) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on the then present estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in section 10-7-302, 10-7-303, 10-7-304, 10-7-305, or 10-7-305.1, then:

(a) The commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by section 10-7-302, 10-7-303, 10-7-304, 10-7-305, or 10-7-305.1;

(b) The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(c) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this part 3, as determined by regulations promulgated by the commissioner.

Source: L. 81: Entire section added, p. 547, § 5, effective July 1.

10-7-306. Calculation of values - supplemental rules. (1) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in sections 10-7-303 to 10-7-305.1 may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall not be less than the amounts used to provide such additions.

(2) Notwithstanding the provisions of section 10-7-303, additional benefits shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this part 3, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits in the following events or circumstances:

(a) In the event of death or dismemberment by accident or accidental means;

(b) In the event of total and permanent disability;

(c) As reversionary annuity or deferred reversionary annuity benefits;

(d) As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this part 3 would not apply;

(e) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid up by reason of the death of a parent of the child;

(f) As other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits.

Source: L. 61: p. 464, § 6. **CRS 53:** § 72-20-6. **C.R.S. 1963:** § 72-19-6. **L. 81:** (1) amended, p. 548, § 6, effective July 1.

10-7-306.1. Calculation of values - new policies. (1) (a) This section, in addition to all other applicable sections of this part 3, shall apply to all policies issued on or after January 1, 1985. Any cash surrender value available under a policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ, by more than two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of:

(I) The greater of zero and the basic cash value specified in this section; and

(II) The present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

(b) The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, corresponding to premiums which would have fallen due on and after such anniversary. However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in section 10-7-303 or 10-7-305, whichever is applicable, shall be the same as are the effects specified in section 10-7-303 or 10-7-305, whichever is applicable, on the cash surrender values defined in that section. The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in section 10-7-305 or 10-7-305.1, whichever is applicable.

(c) Except as is required by subsection (2) of this section, such percentage:

(I) Must be the same percentage for each policy year between the second policy anniversary and the later of:

(A) The fifth policy anniversary; and

(B) The first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(II) Must be such that no percentage after the later of the two policy anniversaries specified in subparagraph (I) of this paragraph (c) may apply to fewer than five consecutive policy years.

(2) No basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in section 10-7-305 or 10-7-305.1, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value. All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other provisions of this part 3. The cash surrender values referred to in this section shall include any endowment benefits provided for by the policy.

(3) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit

available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in sections 10-7-302, 10-7-303, 10-7-304, 10-7-305.1, and 10-7-306. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed in section 10-7-306 shall conform with the principles of this section.

Source: L. 81: Entire section added, p. 548, § 7, effective July 1.

10-7-307. Exemptions. (1) Sections 10-7-302 to 10-7-306.1 shall not apply to any of the following:

(a) Reinsurance;

(b) Group insurance;

(c) A pure endowment;

(d) An annuity or reversionary annuity contract;

(e) Any term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy;

(f) Any term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in sections 10-7-305 and 10-7-305.1, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy;

(g) Any policy which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in sections 10-7-303, 10-7-304, 10-7-305, and 10-7-305.1, exceeds two and one-half percent of the amount of insurance at the beginning of the same policy year; nor

(h) Any policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy.

(2) For purposes of determining the applicability of sections 10-7-302 to 10-7-306.1, the age at expiry for a joint term life insurance policy shall be the age of expiry of the oldest life.

Source: L. 61: p. 464, § 7. **CRS 53:** § 72-20-7. **C.R.S. 1963:** § 72-19-7. **L. 81:** Entire section R&RE, p. 549, § 8, effective July 1.

10-7-308. Waiver prohibited. No agreement between the company and the policyholder or applicant for insurance contrary to the provisions of sections 10-7-301 to 10-7-307, or contrary to the provisions of section 10-3-205, shall be held to waive any of such provisions.

Source: L. 61: p. 465, § 8. **CRS 53:** § 72-20-8. **C.R.S. 1963:** § 72-19-8.

10-7-309. Minimum standard of valuation - rules. (1) Except as otherwise provided in subsection (2) of this section and in section 10-7-309.5, the minimum standard for the

valuation of all policies issued by any domestic or foreign life insurance company, on or after the operative date provided in paragraph (b) of subsection (2) of this section, must be the commissioners reserve valuation methods defined in sections 10-7-310, 10-7-310.5, and 10-7-313, five percent interest for group annuity and pure endowment contracts and three and one-half percent interest for all other such policies and contracts, or in the case of policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1977, five and one-half percent interest for single-premium life insurance policies and four and one-half percent interest for all other such policies, and the following tables:

(a) For ordinary policies of life insurance issued on the standard basis, excluding any disability or accidental death benefits in such policies: The commissioners 1958 standard ordinary mortality table, but, for any category of such policies issued on female risks, all modified net premiums and present values referred to in this part 3 may be calculated, at the option of the company, according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the operative date of section 10-7-305.1:

(I) The commissioners 1980 standard ordinary mortality table; or

(II) At the election of the company for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors; or

(III) Any ordinary mortality table, adopted after 1980 by the NAIC, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies;

(b) For industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in the policies: The 1941 standard industrial mortality table for policies issued prior to the operative date of section 10-7-305 (5), and for policies issued on or after the operative date the commissioners 1961 standard industrial mortality table or any industrial mortality table, adopted after 1980 by the NAIC, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies;

(c) For individual annuity and pure endowment policies, excluding any disability and accidental death benefits in such policies: The 1937 standard annuity mortality table or, at the option of the company, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved by the commissioner;

(d) For group annuity and pure endowment policies, excluding any disability and accidental death benefits in such policies: The group annuity mortality table for 1951, any modification of the table approved by the commissioner, or, at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment policies;

(e) For total and permanent disability benefits in or supplementary to ordinary policies: The tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates, adopted after 1980 by the NAIC, that are approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for the policies. Any table must, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies: The 1959 accidental death benefits table or any accidental death benefits table, adopted after 1980 by the NAIC, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis and other special benefits: Such tables as may be approved by the commissioner.

(2) (a) Except as provided in section 10-7-309.5, the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this subsection (2), as defined in paragraph (b) of this subsection (2), and for all annuities and pure endowments purchased on or after said operative date under group annuity and pure endowment contracts, must be the commissioners reserve valuation methods defined in sections 10-7-310 and 10-7-310.5 and the following tables and interest rates:

(I) For individual single-premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts: The 1971 individual annuity mortality table, or any individual annuity mortality table, adopted after 1980 by the NAIC, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and seven and one-half percent interest;

(II) For individual annuity and pure endowment contracts, other than single-premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts: The 1971 individual annuity mortality table, or any individual annuity mortality table, adopted after 1980 by the NAIC, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and five and one-half percent interest for single-premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other such individual annuity and pure endowment contracts;

(III) For all annuities and pure endowments purchased under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts: The 1971 group annuity mortality table, or any group annuity mortality table, adopted after 1980 by the NAIC, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half percent interest.

(b) On or after July 1, 1977, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection (2) after a specified date but before January 1, 1979, which is the operative date of this subsection (2) for a company, but a company may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If a company makes no such election, the operative date of this subsection (2) for such company is January 1, 1979.

Source: L. 61: p. 466, § 13. **CRS 53:** § 72-20-9. **C.R.S. 1963:** § 72-19-9. **L. 65:** p. 771, § 2. **L. 77:** IP(1) and (1)(a) amended and (2) added, p. 524, § 4, effective July 1. **L. 81:** IP(1),

(1)(a), (1)(b), (1)(e), (1)(f), and (2)(a) amended, p. 550, § 9, effective July 1. **L. 2015:** Entire section amended, (HB 15-1048), ch. 63, p. 160, § 5, effective August 5.

Cross references: For the operative date of this part 3, see § 10-7-315.

10-7-309.5. Minimum standards of valuation for new policies - definition. (1) The calendar year statutory valuation interest rates, as defined in this section, must be the interest rates used in determining the minimum standard for the valuation of:

(a) Life insurance policies issued in a particular calendar year, on or after the operative date of section 10-7-305.1;

(b) Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;

(c) Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and

(d) The net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts.

(2) The calendar year statutory valuation interest rates ("I") shall be determined as follows, and the results rounded to the nearer one-quarter of one percent:

(a) For life insurance:

$$I = .03 + W (R1 - .03) + W/2 (R2 - .09).$$

(b) (I) For single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$$I = .03 + W (R - .03).$$

(II) In the formulas used in paragraph (a) of this subsection (2) and this paragraph (b), "R1" is the lesser of R and .09, "R2" is the greater of R and .09, "R" is the reference interest rate defined in this section, and "W" is the weighting factor defined in this section.

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in paragraph (b) of this subsection (2), the formula for life insurance stated in paragraph (a) of this subsection (2) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single-premium immediate annuities stated in said paragraph (b) shall apply to annuities and guaranteed interest contracts with guarantee durations of ten years or less.

(d) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single-premium immediate annuities stated in paragraph (b) of this subsection (2) shall apply.

(e) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single-premium immediate annuities stated in paragraph (b) of this subsection (2) shall apply.

(3) (a) If the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this paragraph (a) differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for such

life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year.

(b) For purposes of applying the provision of paragraph (a) of this subsection (3), the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when section 10-7-305.1 becomes operative.

(4) The weighting factors referred to in the formulas stated in subsection (2) of this section are given in the following tables:

(a) (I) The weighting factors for life insurance:

GUARANTEE DURATION (YEARS)	WEIGHTING FACTORS
10 or less	.50
More than 10 but not more than 20	.45
More than 20	.35

(II) For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy.

(b) The weighting factor for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options: .80

(c) The weighting factors for other annuities and for guaranteed interest contracts, except as stated in paragraph (b) of this subsection (4), shall be as specified in the following tables (subparagraphs (I), (II), and (III)) and according to the following rules and definitions (subparagraphs (IV), (V), and (VI)):

(I) For annuities and guaranteed interest contracts valued on an issue year basis:

GUARANTEE DURATION (YEARS)	WEIGHTING FACTORS FOR PLAN TYPE		
	A	B	C
5 or less	.80	.60	.50
More than 5 but not more than 10	.75	.60	.50
More than 10 but not more than 20	.65	.50	.45
More than 20	.45	.35	.35

(II) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in subparagraph (I) of this paragraph (c) increased by:

PLAN TYPE		
A	B	C
.15	.25	.05

(III) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in subparagraph (I) or derived in subparagraph (II) of this paragraph (c) increased by:

PLAN TYPE		
A	**B**	**C**
.05	.05	.05

(IV) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(V) "Plan type", as used in the tables in subparagraphs (I), (II), and (III) of this paragraph (c), is defined as follows:

(A) **Plan type A:** At any time policyholder may withdraw funds only: (i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or (ii) without such adjustment but in installments over five years or more; or (iii) as an immediate life annuity; or (iv) no withdrawal permitted.

(B) **Plan type B:** Before expiration of the interest rate guarantee, policyholder may withdraw funds only: (i) with adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or (ii) without such adjustment but in installments over five years or more; or (iii) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

(C) **Plan type C:** Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either: (i) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or (ii) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(VI) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this section, "issue year basis of valuation" refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and "change in fund basis of valuation" refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(5) The "reference interest rate" referred to in subsection (2) of this section shall be defined as follows:

(a) For all life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's Investors Service, Inc.;

(b) For single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or year of purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's Investors Service, Inc.;

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in paragraph (b) of this subsection (5), with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's Investors Service, Inc.;

(d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in paragraph (b) of this subsection (5), with guarantee duration of ten years or less, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's Investors Service, Inc.;

(e) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's Investors Service, Inc.;

(f) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in paragraph (b) of this subsection (5), the average over a period of twelve months, ending on June 30 of the calendar year of the change in the fund, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's Investors Service, Inc.

(6) In the event that Moody's corporate bond yield average - monthly average corporates is no longer published by Moody's Investors Service, Inc., or in the event that the NAIC determines that Moody's corporate bond yield average - monthly average corporates, as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the NAIC and approved by rule promulgated by the commissioner, may be substituted.

Source: L. 81: Entire section added, p. 552, § 10, effective July 1. **L. 2015:** IP(1), (1)(a), (1)(b), (1)(c), and (6) amended, (HB 15-1048), ch. 63, p. 162, § 6, effective August 5.

10-7-310. Life and endowment reserves. (1) Except as otherwise provided in sections 10-7-310.5 and 10-7-313, reserves, according to the commissioners reserve valuation method for

the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of paragraph (a) of this subsection (1) over paragraph (b) of this subsection (1), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; except that such net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy;

(b) A net one-year term premium for such benefits provided for in the first policy year.

(1.5) For any life insurance policy issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit, a cash surrender value, or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date, which for the purposes of this subsection (1.5), means the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium, shall, except as otherwise provided in section 10-7-313, be the greater of the reserve as of such policy anniversary calculated as described in the introductory portion to and paragraphs (a) and (b) of subsection (1) of this section and the reserve as of such policy anniversary calculated as described in said portion and paragraphs of said subsection (1), but with:

(a) The value defined in said paragraph (a) being reduced by fifteen percent of the amount of such excess first year premium;

(b) All present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date;

(c) The policy being assumed to mature on such date as an endowment; and

(d) The cash surrender value provided on such date being considered as an endowment benefit. In making the comparison the mortality and interest bases stated in sections 10-7-309 and 10-7-309.5 shall be used.

(2) Reserves according to the commissioners reserve valuation method for life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums, group annuity and pure endowment policies purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the federal "Internal Revenue Code of 1986", as now or hereafter amended, disability and accidental death benefits in all policies and contracts, and all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and

pure endowment contracts, shall be calculated by a method consistent with the principles of subsection (1) of this section; except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums.

Source: L. 61: p. 467, § 14. **CRS 53:** § 72-20-10. **C.R.S. 1963:** § 72-19-10. **L. 77:** IP(1) and (2) amended, p. 525, § 5, effective July 1. **L. 81:** (1.5) added, p. 557, § 11, effective July 1. **L. 2000:** (2) amended, p. 1840, § 9, effective August 2.

10-7-310.5. Individual annuity and pure endowment reserves. (1) This section applies to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under the federal "Internal Revenue Code of 1986", 26 U.S.C. sec. 408, as now or hereafter amended.

(2) Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contracts, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

Source: L. 77: Entire section added, p. 526, § 6, effective July 1. **L. 2000:** (1) amended, p. 1840, § 10, effective August 2. **L. 2015:** (1) amended, (HB 15-1048), ch. 63, p. 163, § 7, effective August 5.

10-7-311. Minimum aggregate reserves. (1) In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after July 1, 1992, be less than the aggregate reserves calculated in accordance with the methods set forth in sections 10-7-310, 10-7-310.5, 10-7-313, and 10-7-313.1 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(2) In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by section 10-7-114.

Source: L. 61: p. 468, § 15. **CRS 53:** § 72-20-11. **C.R.S. 1963:** § 72-19-11. **L. 77:** Entire section amended, p. 527, § 7, effective July 1. **L. 81:** Entire section amended, p. 557, § 12, effective July 1. **L. 92:** Entire section amended, p. 1497, § 24, effective July 1. **L. 2015:** Entire section amended, (HB 15-1048), ch. 63, p. 163, § 8, effective August 5.

10-7-312. Optional standards. (1) Reserves for any category of policies or benefits as established by the commissioner may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for the category than those calculated according to the minimum standard provided in this part 3, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, must not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in the policies or contracts.

(2) Any company that at any time has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this part 3 may adopt a lower standard of valuation with the approval of the commissioner, but not lower than the minimum provided in this part 3; except that, for the purposes of this part 3, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by section 10-7-114 shall not be deemed to be the adoption of a higher standard of valuation.

Source: L. 61: p. 468, § 16. **CRS 53:** § 72-20-12. **C.R.S. 1963:** § 72-19-12. **L. 77:** (1) amended, p. 527, § 8, effective July 1. **L. 92:** (2) amended, p. 1497, § 25, effective July 1. **L. 2015:** Entire section amended, (HB 15-1048), ch. 63, p. 163, § 9, effective August 5.

10-7-313. Minimum reserves. (1) If in any contract year the gross premium charged by a company on any policy is less than the valuation net premium for the policy calculated by the method used in calculating the reserve on the policy but using the minimum standards of mortality and rate of interest, the minimum reserve required for the policy is the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or the reserve calculated by the method actually used for the policy but using the minimum standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium.

(2) The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in sections 10-7-309 and 10-7-309.5; except that for any life insurance policy issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and that provides an endowment benefit, a cash surrender value, or a combination of endowment benefit and cash surrender value in an amount greater than the excess premium, the provisions of this section must be applied as if the method actually used in calculating the reserve for the policy were the method described in section 10-7-310, ignoring subsection (1.5) of that section. The minimum reserve at each policy anniversary of the policy must be the greater of the minimum reserve calculated in accordance with section 10-7-310, including subsection (1.5) of that section, and the minimum reserve calculated in accordance with this section.

Source: L. 61: p. 469, § 17. **CRS 53:** § 72-20-13. **C.R.S. 1963:** § 72-19-13. **L. 77:** Entire section amended, p. 527, § 9, effective July 1. **L. 81:** Entire section amended, p. 557, § 13, effective July 1. **L. 2015:** Entire section amended, (HB 15-1048), ch. 63, p. 164, § 10, effective August 5.

10-7-313.1. Minimum reserves - exceptions. (1) In the case of any plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurance company based on then-present estimates of future experience, or in the case of any plan of life insurance or annuity that is of such a nature that the minimum reserves cannot be determined by the methods described in sections 10-7-310, 10-7-310.5, and 10-7-313, the reserves that are held under any such plan must:

(a) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(b) Be computed by a method that is consistent with the principles of this part 3, as such appropriateness and method is determined by rules promulgated by the commissioner.

Source: L. 2015: Entire section added, (HB 15-1048), ch. 63, p. 164, § 11, effective August 5.

Editor's note: This section is similar to former § 10-7-313.5 as it existed prior to 2015.

10-7-313.2. Minimum standards for other coverages including accident and health insurance contracts - rules. The commissioner may promulgate rules prescribing minimum standards applicable to the valuation of plans or products not otherwise included within this article and in conformance with standards as adopted by the NAIC. The commissioner shall promulgate rules containing the minimum standards applicable to the valuation of health plans, including disability, sickness, and accident, issued on or after the operative date of this part 3 and prior to the operative date of the valuation manual. For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under section 10-7-101 (2)(a)(IV).

Source: L. 2015: Entire section added, (HB 15-1048), ch. 63, p. 165, § 11, effective August 5.

Editor's note: This section is similar to former § 10-7-313.7 as it existed prior to 2015.

10-7-313.3. Valuation manual for policies issued on or after the operative date of the valuation manual - rules. (1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under section 10-7-101 (2)(a)(IV), except as provided under subsection (5) or (7) of this section.

(2) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(a) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two members, or three-fourths of the members voting, whichever is greater.

(b) The "Standard Valuation Law", as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five percent of the direct premiums written as reported in the following

annual statements submitted for 2008: Life, accident, and health annual statements; health annual statements; or fraternal annual statements.

(c) The "Standard Valuation Law", as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions: The fifty states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual are effective on January 1 following the date when the change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(a) At least three-fourths of the members of the NAIC voting, but not less than a majority of the total membership; and

(b) Members of the NAIC representing jurisdictions totaling greater than seventy-five percent of the direct premiums written as reported in the following annual statements most recently available prior to the vote in paragraph (a) of this subsection (3): Life, accident, and health annual statements; health annual statements; or fraternal annual statements.

(4) The valuation manual must specify all of the following:

(a) Minimum valuation standards for and definitions of the policies or contracts subject to section 10-7-101 (2)(a)(IV). The minimum valuation standards must be:

(I) The commissioners reserve valuation method for life insurance contracts, other than annuity contracts, subject to section 10-7-101 (2)(a)(IV);

(II) The commissioners annuity reserve valuation method for annuity contracts subject to section 10-7-101 (2)(a)(IV); and

(III) Minimum reserves for all other policies or contracts subject to section 10-7-101 (2)(a)(IV).

(b) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in section 10-7-313.4 (1) and the minimum valuation standards consistent with those requirements;

(c) For policies and contracts subject to a principle-based valuation under section 10-7-313.4:

(I) Requirements for the format of reports to the commissioner under section 10-7-313.4 (2)(c), which reports must include information necessary to determine whether the valuation is appropriate and in compliance with this part 3;

(II) Assumptions for risks over which the company does not have significant control or influence;

(III) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of the procedures;

(d) For policies not subject to a principle-based valuation under section 10-7-313.4, the minimum valuation standard must either:

(I) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(II) Develop reserves that quantify the benefits, guarantees, and funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring;

(e) Other requirements, including those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company

experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

(f) The data and form of the data required under section 10-7-313.6, to whom the data must be submitted, and the valuation manual may specify other requirements including data analyses and reporting of analyses.

(5) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this part 3, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by rule.

(6) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company or to review and opine on a company's compliance with any requirement set forth in this part 3. The commissioner may rely upon the opinion, regarding provisions contained within this part 3, of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States. As used in this subsection (6), the term "engage" includes employment and contracting.

(7) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this part 3, and the company shall adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted under this title.

Source: L. 2015: Entire section added, (HB 15-1048), ch. 63, p. 165, § 12, effective August 5.

10-7-313.4. Requirements of a principle-based valuation. (1) A company shall establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual. The valuation must:

(a) Quantify the benefits, guarantees, and funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, the valuation must reflect conditions appropriately adverse to quantify the tail risk.

(b) Incorporate assumptions, risk analysis methods, and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(c) Incorporate assumptions that are derived in one of the following manners:

(I) The assumption is prescribed in the valuation manual.

(II) For assumptions that are not prescribed, the assumptions must:

(A) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(B) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(d) Provide margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(2) A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual must:

(a) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(b) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. The company shall design the controls to assure that all material risks inherent in the liabilities and associated assets subject to the valuation are included in the valuation and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(c) Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(3) A principle-based valuation may include a prescribed formulaic-reserve component.

Source: L. 2015: Entire section added, (HB 15-1048), ch. 63, p. 167, § 12, effective August 5.

10-7-313.5. Minimum reserves - exceptions. (Repealed)

Source: L. 81: Entire section added, p. 558, § 14, effective July 1. **L. 2015:** Entire section repealed, (HB 15-1048), ch. 63, p. 172, § 13, effective August 5.

10-7-313.6. Experience reporting for policies in force on or after the operative date of the valuation manual. A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

Source: L. 2015: Entire section added, (HB 15-1048), ch. 63, p. 168, § 12, effective August 5.

10-7-313.7. Minimum standards for other coverages. (Repealed)

Source: L. 92: Entire section added, p. 1498, § 26, effective July 1. **L. 2015:** Entire section repealed, (HB 15-1048), ch. 63, p. 172, § 13, effective August 5.

10-7-313.8. Confidentiality - definitions. (1) For purposes of this section:

(a) "Confidential information" means:

(I) A memorandum in support of an opinion submitted under section 10-7-114 and any other documents, materials, and other information, including all working papers and copies of working papers, that were created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the memorandum;

(II) All documents, materials, and other information including all working papers and copies of working papers, that were created, produced, or obtained by or disclosed to the commissioner or any other person in the course of an examination made under section 10-7-313.3 (6); except that, if an examination report or other material prepared in connection with an examination made under part 2 of article 1 of this title is not held as private and confidential

information, an examination report or other material prepared in connection with an examination made under section 10-7-313.3 (6) is not confidential information to the same extent as if the examination report or other material had been prepared under part 2 of article 1 of this title;

(III) Any reports, documents, materials, and other information developed by a company in support of or in connection with an annual certification by the company under section 10-7-313.4 (2)(b) that evaluate the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including all working papers and copies of working papers, that were created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the reports, documents, materials, and other information;

(IV) Any principle-based valuation report developed under section 10-7-313.4 (2)(c) and any other documents, materials, and other information, including all working papers and copies of working papers, that were created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the report; and

(V) Experience data, experience materials, and any other documents, materials, data, and other information, including all working papers and copies of working papers, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the experience materials.

(b) "Experience data" means any documents, materials, data, and other information submitted by a company under section 10-7-313.6.

(c) "Experience materials" means experience data and any other documents, materials, data, and other information, including all working papers and copies of working papers, created or produced in connection with the experience data, in each case that include any potentially company identifying or personally identifiable information that is provided to or obtained by the commissioner.

(2) **Privilege for, and confidentiality of, confidential information.** (a) Except as provided in this section, a company's confidential information is confidential by law, privileged, not subject to part 2 of article 72 of title 24, C.R.S., not subject to subpoena, and not subject to discovery or admissible in evidence in any private civil action; except that the commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(b) The commissioner or any person who received confidential information while acting under the authority of the commissioner shall not be permitted or required to testify in any private civil action concerning any confidential information.

(c) (I) In order to assist in the performance of the commissioner's duties, the commissioner may share confidential information:

(A) With other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries; and

(B) In the case of confidential information specified in subparagraphs (I) and (IV) of paragraph (a) of subsection (1) of this section only, with the actuarial board for counseling and discipline, or its successor, upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law enforcement officials.

(II) The commissioner may share confidential information under sub-subparagraphs (A) and (B) of subparagraph (I) of this paragraph (c) only if the recipient agrees, and has the legal

authority to agree, to maintain the confidentiality and privileged status of the confidential information in the same manner and to the same extent as required for the commissioner.

(d) Except as provided in this section, the commissioner may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, or information from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the actuarial board for counseling and discipline, or its successor, and shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, data, or other information.

(e) The commissioner may enter into agreements governing sharing and use of information consistent with this section.

(f) No waiver of any applicable privilege or claim of confidentiality in the confidential information may occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in this section.

(g) A company may assert a privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section, and the privilege shall be enforced in any proceeding in, and in any court of, this state.

(h) As used in this section, "regulatory agency", "law enforcement agency", and the "NAIC" include their employees, agents, consultants, and contractors.

(3) Notwithstanding subsection (2) of this section, confidential information specified in paragraphs (a) and (c) of subsection (1) of this section:

(a) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under section 10-7-114 or principle-based valuation report developed under section 10-7-313.4 (2)(c) by reason of an action required by this part 3 or by rules promulgated under this part 3;

(b) May otherwise be released by the commissioner with the written consent of the company; and

(c) Once any portion of a memorandum in support of an opinion submitted under section 10-7-114 or a principle-based valuation report developed under section 10-7-313.4 (2)(c) is cited by the company in its marketing or is publicly volunteered to a governmental agency other than a state insurance department or is released by the company to the news media, all portions of the memorandum or report are no longer confidential.

Source: L. 2015: Entire section added, (HB 15-1048), ch. 63, p. 169, § 12, effective August 5.

10-7-313.9. Single state exemption. (1) The commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in Colorado from the requirements of section 10-7-313.3 if:

(a) The commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(b) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the commissioner and promulgated by rule.

(2) For any company granted an exemption under this section, sections 10-7-114 and 10-7-309 to 10-7-313.2 are applicable. With respect to any company applying this exemption, any reference to section 10-7-313.3 found in sections 10-7-114 and 10-7-309 to 10-7-313.2 is not applicable.

Source: L. 2015: Entire section added, (HB 15-1048), ch. 63, p. 171, § 12, effective August 5.

10-7-314. Automatic premium loans. Nothing in this part 3 shall be construed to prohibit the company from including in its policies a provision for automatic premium loans to prevent premium default.

Source: L. 61: p. 469, § 18. **CRS 53:** § 72-20-14. **C.R.S. 1963:** § 72-19-14.

10-7-315. Operative date. At any time after April 11, 1961, and before January 1, 1966, any company may file with the commissioner a written notice of its election to comply with the provisions of this part 3 after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date (which shall be the operative date of this part 3 for such company) this part 3 shall become operative with respect to policies thereafter issued by such company. If a company makes no such election, the operative date of this part 3 for such company shall be January 1, 1966.

Source: L. 61: p. 469, § 19. **CRS 53:** § 72-20-15. **C.R.S. 1963:** § 72-19-15.

10-7-316. Effect on existing policies. Nothing in this part 3 shall be construed as affecting any policy issued by any company prior to the operative date provided for in section 10-7-315.

Source: L. 61: p. 469, § 20. **CRS 53:** § 72-20-16. **C.R.S. 1963:** § 72-19-16.

PART 4

VARIABLE CONTRACTS

10-7-401. Sales not prohibited. The provisions of section 10-3-1104 shall not prohibit the sale and issuance by life insurance companies of contracts providing for payments which vary directly according to investment experience in connection with the sale and issuance by such life insurance companies of other forms of life insurance and annuities as are provided for in this title.

Source: L. 61: p. 447, § 5. **CRS 53:** § 72-2-18. **C.R.S. 1963:** § 72-2-16.

10-7-402. Investment contract funds - separate accounts. (1) A domestic life insurance company may establish one or more separate accounts and may allocate thereto amounts, including without limitation proceeds applied under optional modes of settlement or under dividend options, to provide for life insurance or annuities and benefits incidental thereto, payable in fixed or variable amounts or both and may accumulate or hold funds paid pursuant to funding agreements or guaranteed investment contracts, subject to the following:

(a) The income, gains, and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains, or losses of the company.

(b) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in paragraph (c) of this subsection (1), amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies, and the investments in such separate account shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

(c) Except with the approval of the commissioner and under such conditions as to investments and other matters as he may prescribe, which shall recognize the guaranteed nature of the benefits provided, reserves for benefits guaranteed as to dollar amount and duration and for funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account.

(d) Unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation or, if there is no readily available market, as provided under the terms of the contract or the rules or other written agreement applicable to such separate account; except that, unless otherwise approved by the commissioner, that portion, if any, of the assets of such separate account equal to the company's reserve liability as provided in paragraph (c) of this subsection (1) shall be valued in accordance with the rules otherwise applicable to the company's assets.

(e) Amounts allocated to a separate account in the exercise of the power granted by this section shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts. To the extent provided under the applicable contracts, that portion of the assets of any such separate account which is equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

(f) No sale, exchange, or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value, if such transfer of securities is approved by the commissioner. The commissioner may approve other transfers among such accounts if, in his opinion, such transfers would not be inequitable.

(g) To the extent such company deems it necessary to comply with any applicable federal or state laws, such company, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment

trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with such company, to manage the business of such account.

Source: L. 71: p. 712, § 1. **C.R.S. 1963:** § 72-2-45. **L. 2003:** IP(1) amended, p. 2045, § 1, effective May 22.

10-7-403. Where benefits are payable in variable amounts. Any contract providing benefits payable in variable amounts, delivered or issued for delivery in this state, shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of such variable benefits. Any such contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will so vary and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

Source: L. 71: p. 713, § 1. **C.R.S. 1963:** § 72-2-46.

10-7-404. Authority to issue variable contracts. (1) No company shall deliver or issue for delivery within this state variable contracts unless it is licensed to do a life insurance or annuity business in this state and the commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the commissioner shall consider among other things:

(a) The history and financial condition of the company;

(b) The character, responsibility, and fitness of the officers and directors of the company; and

(c) The law and regulations under which the company is authorized in the state of domicile to issue variable contracts.

(2) If the company is a subsidiary of an admitted life insurance company or affiliated with such company through common management or ownership, it may be deemed by the commissioner to have complied with the provisions of this section if either it or the parent or the affiliated company meets the requirements of this section.

Source: L. 71: p. 713, § 1. **C.R.S. 1963:** § 72-2-47.

10-7-405. Construction. (1) Notwithstanding any other provision of law, the commissioner has sole authority to regulate the issuance and sale of variable contracts and to issue such reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of sections 10-7-402 to 10-7-405.

(2) Except for sections 10-3-204, 10-7-102 (1)(g) to (1)(i), 10-7-202 (1)(a), 10-7-302 to 10-7-306, and 10-7-501 to 10-7-510, and, except as otherwise provided in sections 10-7-402 to

10-7-405, all pertinent provisions of this title shall apply to separate accounts and contracts relating thereto. Any individual variable life insurance or annuity contract, delivered or issued for delivery in this state, shall contain grace, reinstatement, and nonforfeiture provisions appropriate to such a contract. The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(3) Notwithstanding any other provision of law, the term "company" as used in sections 10-7-402 to 10-7-404 includes fraternal benefit societies licensed to do business in this state under article 14 of this title.

Source: L. 71: p. 714, § 1. **C.R.S. 1963:** § 72-2-48. **L. 77:** (2) amended, p. 528, § 10, effective July 1.

PART 5

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

10-7-501. Short title. This part 5 shall be known and may be cited as the "Standard Nonforfeiture Law for Individual Deferred Annuities".

Source: L. 77: Entire part added, p. 528, § 11, effective July 1.

10-7-502. Exemptions. This part 5 shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the federal "Internal Revenue Code of 1986", as now or hereafter amended. Nor shall this part 5 apply to any premium deposit fund, variable annuity, investment annuity, immediate annuity, deferred annuity contract after annuity payments have commenced, or reversionary annuity, or to any contract delivered outside this state through an agent or other representative of the company issuing the contract.

Source: L. 77: Entire part added, p. 528, § 11, effective July 1. **L. 2000:** Entire section amended, p. 1840, § 11, effective August 2.

10-7-503. Compulsory contract provisions. (1) No contract of annuity, except as stated in section 10-7-502, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which, in the opinion of the commissioner, are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

(a) That, upon cessation of payment of considerations under a contract or upon written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in sections 10-7-505 to 10-7-508 and 10-7-509 (1);

(b) If a contract provides for a lump-sum settlement, that, upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in sections 10-7-505, 10-7-506, 10-7-508, and 10-7-509 (1). The company may reserve the right to defer the payment of such cash surrender benefit for a period not to exceed six months after demand with surrender of the contract after requesting in writing and receiving approval in writing from the commissioner. The request shall address the necessity and equitability of the deferral to all policyholders.

(c) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits;

(d) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract shall not be less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.

(2) Notwithstanding subsection (1) of this section, a deferred annuity contract may provide that, if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars monthly, the company may terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract. A contract that does not provide cash surrender or death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of an annuity payment shall include a statement in a prominent place in the contract that such benefits are not provided.

Source: L. 77: Entire part added, p. 528, § 11, effective July 1. **L. 2004:** (1)(a), (1)(b), and (1)(d) amended and (2) added, p. 817, § 1, effective July 1.

10-7-504. Minimum nonforfeiture amounts - rules. (1) The minimum values specified in sections 10-7-505 to 10-7-508 and 10-7-509 (1) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon the following minimum nonforfeiture amounts:

(a) (I) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest authorized by subsection (3) of this section of the net considerations, as defined in subsection (2) of this section, paid prior to such time, decreased by the following:

(A) The sum of any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest authorized by subsection (3) of this section;

(B) An annual contract charge of fifty dollars, accumulated at rates of interest authorized by subsection (3) of this section;

(C) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(II) (Deleted by amendment, L. 2004, p. 818, § 2, effective July 1, 2004.)

(b) and (c) (Deleted by amendment, L. 2004, p. 818, § 2, effective July 1, 2004.)

(2) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be equal to eighty-seven and one-half percent of the gross considerations credited to the contract during such contract year.

(3) (a) The interest rate used to determine minimum nonforfeiture amounts shall be the lesser of the following:

(I) Three percent per annum; or

(II) If specified in the contract that the interest rate will reset, the five-year constant maturity treasury rate reported by the federal reserve as of a specified date or averaged over a period reduced by one hundred twenty-five basis points so long as:

(A) The rate is rounded to the nearest one-twentieth of one percent;

(B) The reset is specified in the contract to be no longer than fifteen months before the contract issue or redetermination date under sub-subparagraph (E) of this subparagraph (II);

(C) The resulting interest is not less than fifteen one-hundredths percent;

(D) The interest rate applies for an initial period and may be redetermined for additional periods;

(E) Any redetermination date, basis, and period is stated in the contract; and

(F) The basis is the date or average over a specified period that produces the value of the five-year constant maturity treasury rate used at each redetermination date.

(b) During the period or term that a contract provides substantive participation in an equity indexed benefit, the contract may increase the reduction authorized in subparagraph (II) of paragraph (a) of this subsection (3) by an additional rate not to exceed one hundred basis points to reflect the value of the equity indexed benefit. The present value of the additional reduction at the contract issue date and at each redetermination date shall not exceed the market value of the benefit. The commissioner may disallow or limit the additional reduction.

(c) The commissioner may adopt rules to implement paragraph (b) of this subsection (3) and to provide further adjustments to the minimum forfeiture amounts for contracts that provide substantive participation in an equity indexed benefit and for other contracts for which the commissioner determines adjustments are justified.

Source: L. 77: Entire part added, p. 529, § 11, effective July 1. **L. 2003:** (1)(a) amended, p. 1345, § 1, effective August 6. **L. 2004:** Entire section amended, p. 818, § 2, effective July 1. **L. 2021:** (3)(a)(II)(C) amended, (SB 21-259), ch. 387, p. 2587, § 1, effective June 30.

10-7-505. Computation of annuity benefit. Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

Source: L. 77: Entire part added, p. 530, § 11, effective July 1.

10-7-506. Computation of cash surrender benefit. For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at the time of surrender. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

Source: L. 77: Entire part added, p. 530, § 11, effective July 1.

10-7-507. Computation of paid-up annuity nonforfeiture benefit. (1) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract.

(2) For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at the time of the insured's death.

Source: L. 77: Entire part added, p. 530, § 11, effective July 1.

10-7-508. Determination of maturity date. For the purpose of determining the benefits calculated under sections 10-7-506 and 10-7-507, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

Source: L. 77: Entire part added, p. 531, § 11, effective July 1.

10-7-509. Calculations of values - supplemental rules. (1) Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the

lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(2) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of sections 10-7-505 to 10-7-508 and subsection (1) of this section, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts and paid-up annuity, cash surrender, and death benefits that may be required by this part 5. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless additional benefits separately would require minimum nonforfeiture amounts and paid-up annuity, cash surrender, and death benefits.

Source: L. 77: Entire part added, p. 531, § 11, effective July 1.

10-7-510. Effective date - applicability of part. On or after July 1, 2004, a company may elect to apply this part 5 to annuity contracts on a contract form-by-contract form basis. Otherwise, this part 5 shall apply to all annuity contracts created on or after July 1, 2005, and between July 1, 2004, and July 1, 2005, this part 5 as it existed on June 30, 2004, shall apply to all other annuity contracts.

Source: L. 77: Entire part added, p. 531, § 11, effective July 1. **L. 2004:** Entire section amended, p. 820, § 3, effective July 1.

10-7-511. Rule-making authority. The commissioner may adopt rules to implement this part 5.

Source: L. 2004: Entire section added, p. 821, § 4, effective July 1.

PART 6

VIATICAL SETTLEMENTS

10-7-601. Short title. This part 6 shall be known and may be cited as the "Viatical Settlements Act".

Source: L. 2005: Entire part added, p. 1293, § 1, effective January 1, 2006.

10-7-602. Definitions. As used in this part 6, unless the context otherwise requires:

(1) "Advertising" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the

internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed directly before the public in this state for the purpose of creating an interest in or inducing a person to sell, assign, devise, bequest, or transfer the death benefit or ownership of a policy pursuant to a viatical settlement contract.

(2) "Business of viatical settlements" means an activity that involves, but is not necessarily limited to, the offering, solicitation, negotiation, procurement, effectuation, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, or hypothecating of viatical settlement contracts.

(3) "Chronically ill", with reference to an individual, means that the individual:

(a) Suffers from a disease or disability that prevents the individual from independently performing two or more routine but necessary activities of daily living, which activities include, without limitation, eating, toileting, transferring, bathing, dressing, or continence;

(b) Requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(c) Has a level of disability similar to that described in paragraph (a) of this subsection (3), as determined by the federal department of health and human services.

(4) (a) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or entity that has a direct ownership in a policy that is the subject of a viatical settlement contract, and:

(I) Whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies; and

(II) Who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts or to provide stop-loss insurance.

(b) "Financing entity" does not include a nonaccredited investor.

(5) "Fraudulent viatical settlement act" includes:

(a) An act or omission by a person who, knowingly or with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits or engages in, or permits its employees or agents to commit or engage in, acts including:

(I) Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, financing entity, insurer, insurance producer, or other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(A) An application for the issuance of a viatical settlement contract or policy;

(B) The underwriting of a viatical settlement contract or policy;

(C) A claim for payment or benefit pursuant to a viatical settlement contract or policy;

(D) Premiums paid on a policy;

(E) Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or policy;

(F) The reinstatement or conversion of a policy;

(G) The solicitation, offer, effectuation, or sale of a viatical settlement contract or policy;

(H) The issuance of written evidence of a viatical settlement contract or policy; or

(I) A financing transaction;

(II) Employing any device, scheme, or artifice to defraud related to viaticated policies;

(b) In the furtherance of a fraud or to prevent the detection of a fraud a person commits or permits its employees or agents to:

(I) Remove, conceal, alter, destroy, or sequester from the commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;

(II) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(III) Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or

(IV) File with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceal information about a material fact from the commissioner;

(c) Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, life insurance producer, insurer, insured, viator, policyowner, or other person engaged in the business of viatical settlements or insurance;

(d) Recklessly entering into, negotiating, or otherwise dealing in a viatical settlement contract, the subject of which is a policy that was obtained by presenting false information concerning a fact material to the policy, or by concealing, for the purpose of misleading another, information concerning a fact material to the policy, where the viator or the viator's agent intended to defraud the insurance company that issued the policy. "Recklessly" means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, when such disregard involves a gross deviation from acceptable standards of conduct.

(e) Attempting to commit, assist, aid or abet in the commission of, or conspiracy to commit, the acts or omissions specified in this subsection (5).

(6) "Life insurance producer" means a person licensed as a resident or nonresident insurance producer pursuant to article 2 of this title who has received qualification for life insurance coverage or a life line of coverage pursuant to section 10-2-407 (1)(a).

(7) "NAIC" means the national association of insurance commissioners or any analogous successor organization.

(8) "Person" means a natural person or a legal entity including, but not limited to, an individual, partnership, limited liability company, association, trust, or corporation.

(9) "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state.

(10) "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in viaticated policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the commissioner as if those records and files were maintained directly by the licensed viatical settlement provider.

(11) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed only to provide, either directly or indirectly, access to institutional capital markets for a financing entity or licensed viatical settlement provider.

(12) "Terminally ill" means having an illness or sickness that is reasonably expected to result in death in twenty-four months or less.

(13) "Viatical settlement contract" means a written agreement establishing the terms under which compensation or anything of value is paid, which compensation or value is less than the expected death benefit of the policy, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the policy. "Viatical settlement contract" includes a contract for a loan or other financing transaction with a viator secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the policy, or a loan secured by the cash value of a policy. "Viatical settlement contract" also includes an agreement with a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator. "Viatical settlement contract" does not mean a written agreement entered into between a viator and a person having an insurable interest in the insured's life.

(14) "Viatical settlement provider" means a person, other than a viator, who enters into or effectuates a viatical settlement contract. "Viatical settlement provider" does not include:

(a) A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a policy as collateral for a loan;

(b) The issuer of a policy providing accelerated benefits pursuant to the policy;

(c) An authorized or eligible insurer that provides stop-loss coverage to a viatical settlement provider, financing entity, special purpose entity, or related provider trust;

(d) A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of policies for any value less than the expected death benefit;

(e) A financing entity;

(f) A special purpose entity;

(g) A related provider trust; or

(h) An accredited investor or qualified institutional buyer as defined, respectively, in regulation D, rule 501, or rule 144A of the federal "Securities Act of 1933", as amended, who purchases a viaticated policy from a viatical settlement provider.

(15) "Viaticated policy" means a policy that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

(16) "Viator" means the owner of a policy who is a resident of this state and who enters or seeks to enter into a viatical settlement contract. For the purposes of this part 6, a viator is not limited to an owner of a policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed. If there is more than one owner on a single policy and the owners are residents of different states, the transaction shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all owners. "Viator" does not include:

(a) A licensee as provided by this part 6, including a life insurance producer;

(b) An accredited investor or qualified institutional buyer as defined, respectively, in regulation D, rule 501, or rule 144A of the federal "Securities Act of 1933", as amended;

(c) A financing entity;
(d) A special purpose entity; or
(e) A related provider trust.

Source: L. 2005: Entire part added, p. 1293, § 1, effective January 1, 2006.

Cross references: For regulation D, rule 501, see 17 CFR 230.501; for rule 144A, see 17 CFR 230.144A.

10-7-603. Licensing. (1) (a) No person shall act on behalf of a viator or otherwise negotiate, as defined in section 10-2-103 (7.9), viatical settlement contracts between a viator and one or more viatical settlement providers unless such person is a life insurance producer and has been licensed as a resident producer with a life line of authority in his or her home state for at least one year.

(b) Not later than thirty days after the first day of negotiating a viatical settlement on behalf of a viator, the life insurance producer shall notify the commissioner of the activity on a form prescribed by the commissioner, and shall pay an applicable fee to be determined by the commissioner by rule. Notification shall include an acknowledgment by the life insurance producer that he or she will operate in accordance with this part 6.

(c) Irrespective of the manner in which the life insurance producer is compensated, a life insurance producer is deemed to represent only the viator, and the insurer that issued the policy being viaticated shall not be responsible for any act or omission of a life insurance producer or viatical settlement provider arising out of or in connection with the viatical settlement transaction, unless the insurer receives compensation from the viatical settlement provider or life insurance producer for the viatical settlement contract.

(d) Notwithstanding paragraph (a) of this subsection (1), a person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider may negotiate viatical settlement contracts without having to obtain a license as a life insurance producer.

(2) (a) No person may operate as a viatical settlement provider without first obtaining a viatical settlement provider license from the commissioner.

(b) Application for a viatical settlement provider license shall be made to the commissioner on a form prescribed by the commissioner, and an application shall be accompanied by a fee to be determined by the commissioner by rule.

(c) A license may be renewed from year to year, on the anniversary date of initial issuance, upon payment of an annual renewal fee as determined by the commissioner by rule. Failure to pay the fee by the renewal date shall result in expiration of the license.

(d) The applicant for a viatical settlement provider license shall provide information on forms prescribed by the commissioner. The commissioner may, at any time, require the applicant to fully disclose the identity of all stockholders, partners, officers, members, and employees, except stockholders owning fewer than five percent of the shares of an applicant whose shares are publicly traded, and the commissioner may refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner, or member of the entity who may materially influence the entity's conduct meets the standards of this article.

(e) A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as viatical settlement providers, as applicable, under the license, if all of those persons are named in the application and any supplements to the application.

(f) Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and issue a license if the commissioner finds that the applicant:

(I) Has provided a detailed plan of operation;

(II) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license for which an application was submitted;

(III) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for the license for which an application was submitted;

(IV) If a legal entity, provides a certificate of good standing from the state of its domicile; and

(V) Has provided an anti-fraud plan that meets the requirements of this part 6.

(g) The commissioner may not issue a license to a nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the commissioner or unless the applicant has filed with the commissioner the applicant's written, irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner.

(h) A viatical settlement provider shall provide to the commissioner new or revised information about officers, stockholders who own ten percent or more of the provider's stock, and all partners, directors, members, and designated employees within thirty days after the change.

Source: L. 2005: Entire part added, p. 1298, § 1, effective January 1, 2006.

10-7-604. Licensure - refusal to issue - suspension - revocation - refusal to renew. (1) The commissioner shall refuse to issue, suspend, revoke, or refuse to renew the license of a viatical settlement provider if the commissioner finds after compliance with subsection (3) of this section that:

(a) There was any material misrepresentation in the application for the license;

(b) The licensee or any of its officers, partners, members, or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent;

(c) The licensee demonstrates a pattern of unreasonable payments to viators;

(d) The licensee or any of its officers, partners, members, or key management personnel has been found guilty of, or has pleaded guilty or nolo contendere to, any felony, or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment or conviction has been entered by the court;

(e) The licensee has entered into any viatical settlement contract that has not been approved pursuant to this part 6;

(f) The licensee has failed to honor contractual obligations set out in a viatical settlement contract;

(g) The licensee no longer meets the requirements for initial licensure;

(h) The licensee has assigned, transferred, or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this state; an accredited investor or qualified institutional buyer as defined, respectively, in regulation D, rule 501, or rule 144A of the federal "Securities Act of 1933", as amended; a financing entity; a special purpose entity; or a related provider trust; or

(i) The applicant or licensee or any of its officers, partners, members, or key management personnel, or any life insurance producer acting on behalf of the applicant or licensee, has violated this part 6.

(2) The commissioner may suspend, revoke, or refuse to renew the license of a life insurance producer if the commissioner finds that such life insurance producer has violated this part 6.

(3) If the commissioner denies a license application or suspends, revokes, or refuses to renew the license of a viatical settlement provider, or suspends, revokes, or refuses to renew the license of a life insurance producer, the commissioner shall conduct a hearing in accordance with the "State Administrative Procedure Act", article 4 of title 24, C.R.S., and may use a hearing officer pursuant to section 10-1-127.

Source: L. 2005: Entire part added, p. 1300, § 1, effective January 1, 2006.

Cross references: For regulation D, rule 501, see 17 CFR 230.501; for rule 144A, see 17 CFR 230.144A.

10-7-605. Forms approval. A person may not use a viatical settlement contract or provide to a viator a disclosure statement form in this state unless such contract or form is first filed with and approved by the commissioner. Any settlement contract form or disclosure form filed with the commissioner shall be deemed approved if it has not been disapproved within sixty days after the filing. The commissioner shall disapprove a viatical settlement contract form or disclosure statement form if, in the commissioner's opinion, the contract or provisions contained in it are unreasonable, contrary to the interests of the public, or misleading or unfair to the viator.

Source: L. 2005: Entire part added, p. 1301, § 1, effective January 1, 2006.

10-7-606. Annual reports. (1) Each viatical settlement provider shall file with the commissioner by March 1 of each year an annual statement containing such information as the commissioner prescribes by rule. This information is limited to only those transactions in which the viator is a resident of this state and does not include individual transaction data regarding the business of viatical settlements or data that compromises the privacy of personal, financial, or health information of the viator or insured.

(2) Except as otherwise allowed or required by law, a viatical settlement provider, life insurance producer, information bureau, rating agency or company, or other person with actual knowledge of a viator or insured's identity may not disclose that identity as a viator or insured or the viator's or insured's financial or medical information to another person unless the disclosure is:

(a) (I) Necessary to effect a viatical settlement contract between the viator and a viatical settlement provider; and

(II) The viator or insured or both, as may be required, have provided prior written consent to the disclosure;

(b) Provided in response to an investigation or examination by the commissioner or another governmental officer or agency or pursuant to this article;

(c) A term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

(d) Necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(e) Necessary to allow the viatical settlement provider or its authorized representative to make contacts for the purpose of determining health status; or

(f) Required to purchase stop-loss coverage.

Source: L. 2005: Entire part added, p. 1301, § 1, effective January 1, 2006.

10-7-607. Examinations. (1) **Authority, scope, and scheduling of examinations.** (a) The commissioner may conduct an examination under this part 6 of a licensee as often as the commissioner in his or her sole discretion deems appropriate.

(b) For purposes of completing an examination of a licensee under this part 6, the commissioner may examine or investigate any person, or the business of any person, in so far as the examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the licensee.

(c) In lieu of an examination under this part 6 of any foreign or alien licensee licensed in this state, the commissioner may, at the commissioner's discretion, accept an examination report on the licensee as prepared by the commissioner for the licensee's state of domicile or port-of-entry state.

(2) **Record retention requirements.** (a) A person required to be licensed under this part 6 shall for five years retain copies of all:

(I) Proposed, offered, or executed contracts, underwriting documents, policy forms, and applications from the date of the proposal, offer, or execution of the contract, whichever is later;

(II) Checks, drafts, or other evidence and documentation related to the payment, transfer, deposit, or release of moneys from the date of the transaction; and

(III) Other records and documents related to the requirements of this part 6.

(b) This section does not relieve a person of the obligation to produce the documents listed in paragraph (a) of this subsection (2) to the commissioner after the retention period has expired if the person has retained the documents.

(c) Records required to be retained by this subsection (2) shall be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

(3) **Conduct of examinations.** (a) Upon determining that an examination should be conducted, the commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing the examiner as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and

procedures set forth in the examiner's handbook adopted by the NAIC. The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate.

(b) Every licensee or person from whom information is sought, and its officers, directors, and agents, shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the commissioner shall be grounds for suspension, refusal, or nonrenewal of any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the commissioner's jurisdiction. Any proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S.

(c) The commissioner shall have the power to issue subpoenas, to administer oaths, and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction and, upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

(d) When making an examination under this part 6, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The reasonable cost of such examiners' services shall be borne by the licensee that is the subject of the examination.

(e) Nothing contained in this part 6 shall be construed to limit the commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(f) Nothing contained in this part 6 shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action that the commissioner may, in his or her sole discretion, deem appropriate.

(g) The licensee shall pay the charges incurred in the examination, including the expenses of the commissioner or the commissioner's designee and the expenses and compensation of the commissioner's examiners and assistants. If a licensee believes that the fees assessed are unreasonable in relation to the examination performed, the licensee may appeal the assessments to and seek judicial review by the district court in and for the city and county of Denver pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S. If no hearing is requested or, if after a hearing and appeal process, the licensee refuses or fails to pay, the commissioner or his designee shall promptly institute a civil action against the licensee to recover the expenses of examination.

(4) **Examination reports.** (a) Examination reports shall consist only of facts appearing upon the books, records, or other documents of the licensee, its agents, or other persons examined, or as ascertained from the testimony of its officers or agents or other persons

examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(b) No later than sixty days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath. Upon receipt of the verified report, the commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(c) Within thirty days after the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers, and enter an order:

(I) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the licensee is operating in violation of any law, rule, or prior order of the commissioner, the commissioner may order the licensee to take any action the commissioner considers necessary and appropriate to cure the violation.

(II) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information and refiling; or

(III) Calling for an investigatory hearing with no less than twenty days' notice to the licensee for purposes of obtaining additional documentation, data, information, and testimony.

(d) All orders entered pursuant to this subsection (4) shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, the relevant examiner workpapers, and any written submissions or rebuttals. Any examination warrant issued pursuant to paragraph (a) of subsection (3) of this section shall be considered a final administrative decision, review of which may be sought in the district court in and for the city and county of Denver pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S., and shall be served upon the licensee by certified mail together with a copy of the adopted examination report. Within thirty days after the issuance of the adopted report, the licensee shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(e) Hearings conducted pursuant to this section shall be subject to the following requirements:

(I) Any hearing conducted pursuant to this section by the commissioner or the commissioner's authorized representative shall be conducted as a nonadversarial, confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant workpapers or by the written submission or rebuttal of the licensee. Within twenty days after the conclusion of any hearing, the commissioner shall enter an order pursuant to subparagraph (I) of paragraph (c) of this subsection (4).

(II) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously, with discovery by the licensee limited to the examiner's workpapers that tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or the commissioner's representative may issue subpoenas for the attendance of any witnesses or the production of any documents

considered relevant to the investigation, whether under the control of the commissioner, the company, or other persons. The documents produced shall be included in the record, and testimony taken by the commissioner or the commissioner's representative shall be under oath and preserved for the record. Nothing contained in this section shall require the commissioner to disclose any information or records that would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(III) The hearing shall proceed with the commissioner or the commissioner's representative posing questions to the persons subpoenaed. Thereafter, the licensee and the division may present testimony relevant to the investigation. Cross-examination may be conducted only by the commissioner or the commissioner's representative. The licensee and the commissioner shall be permitted to make closing statements and may be represented by counsel of their choice.

(f) If the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate any proceedings or actions provided by law.

(g) No provision of this part 6 shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, a preliminary examination report or its results, or any related matter to the insurance division of this or any other state or country, to law enforcement officials of this or any other state, or to any agency of the federal government at any time, subject to the written agreement of the recipient to hold such information confidential and to treat it in a manner consistent with this part 6.

(5) **Confidentiality of examination information.** (a) Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the commissioner unless required by law.

(b) (I) Except as otherwise provided in this part 6, all examination reports, working papers, recorded information, and documents, and copies thereof, produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made under this part 6, or in the course of analysis or investigation by the commissioner of the financial condition or market conduct of a licensee, are:

(A) Confidential by law and privileged;

(B) Not subject to article 72 of title 24, C.R.S.;

(C) Not subject to subpoena; and

(D) Not subject to discovery or admissible in evidence in any private civil action.

(II) The commissioner is authorized to use the documents, materials, or other information described in subparagraph (I) of this paragraph (b) in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(III) For the purposes of this paragraph (b), "this part 6" includes the law of another state or jurisdiction that is substantially similar to this part 6.

(c) Documents, materials, or other information, including, but not limited to, all working papers and copies thereof in the possession or control of the NAIC and its affiliates and subsidiaries are:

(I) Confidential by law and privileged;

(II) Not subject to subpoena; and

(III) Not subject to discovery or admissible in evidence in any private civil action if they are:

(A) Created, produced, or obtained by or disclosed to the NAIC and its affiliates and subsidiaries in the course of assisting an examination made under this part 6, or assisting the commissioner in the analysis or investigation of the financial condition or market conduct of a licensee; or

(B) Disclosed to the NAIC or its affiliates and subsidiaries under paragraph (d) of this subsection (5) by the commissioner.

(d) The commissioner or any person that received the documents, material, or other information while acting under the authority of the commissioner, including the NAIC and its affiliates and subsidiaries, is permitted to testify in any private civil action concerning any confidential documents, materials, or information subject to paragraph (a) of this subsection (5).

(e) In order to assist in the performance of the commissioner's duties, the commissioner:

(I) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to paragraph (a) of this subsection (5), with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities if the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(II) May receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(III) May enter into agreements governing the sharing and use of information consistent with this subsection (5).

(f) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in paragraph (e) of this subsection (5).

(g) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection (5) shall be available and enforced in any proceeding in, and in any court of, this state.

(h) Nothing contained in this part 6 shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, a preliminary examination report or its results, or any related matter to the commissioner of any other state or country, to law enforcement officials of this or any other state or agency of the federal government at any time, or to the NAIC, if the person receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this part 6.

(i) Nothing in this part 6 shall immunize a party who discloses information to the commissioner from disclosing that information pursuant to an independent inquiry or restrict the admissibility of such independently obtained information.

(6) **Conflict of interest.** (a) An examiner may not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of, or owns a pecuniary interest in, any person subject to examination under this part 6. This section shall not be construed to automatically preclude an examiner from being:

(I) A viator;

(II) An insured in a viaticated policy; or

(III) A beneficiary in an insurance policy that is proposed to be the subject of a viatical settlement contract.

(b) Notwithstanding any provision of paragraph (a) of this subsection (6) to the contrary, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under provisions of this part 6.

(7) **Cost of examinations.** The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

(8) **Immunity from liability.** (a) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives, or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this part 6.

(b) No cause of action shall arise from, nor shall any liability be imposed against any person for, the act of communicating or delivering information or data to the commissioner, the commissioner's authorized representative, or an examiner pursuant to an examination made under this part 6, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph (b) does not abrogate or modify in any way any common law or statutory privilege or immunity enjoyed by any person identified in paragraph (a) of this subsection (8).

(c) A person identified in paragraph (a) or (b) of this subsection (8) shall be entitled to an award of attorney fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this part 6, and the party bringing the action was not substantially justified in doing so. For purposes of this paragraph (c), a proceeding is substantially justified if it had a reasonable basis in law or fact at the time that it was initiated.

(9) **Investigative authority of the commissioner.** The commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

Source: L. 2005: Entire part added, p. 1302, § 1, effective January 1, 2006.

10-7-608. Disclosures. (1) With each application for a viatical settlement contract, a viatical settlement provider or life insurance producer shall provide the viator with at least the following information, in a separate document signed by the viator and the viatical settlement provider or life insurance producer, no later than the time the application for the viatical settlement contract is signed by all parties:

(a) That there exist possible alternatives to a viatical settlement contract, including any accelerated death benefits or policy loans offered under the viator's life insurance policy;

(b) That some or all of the proceeds of the viatical settlement contract may be taxable under federal income tax and state franchise and income taxes, and assistance may be sought from a professional tax advisor;

(c) That proceeds of the viatical settlement contract may be subject to the claims of creditors;

(d) That receipt of the proceeds of a viatical settlement contract may adversely affect the viator's eligibility for medicaid or other government benefits or entitlements, and advice may be obtained from the appropriate government agencies;

(e) That the viator has the right to rescind a viatical settlement contract before the earlier of thirty calendar days after the date upon which the viatical settlement contract is executed by all parties or fifteen calendar days after the receipt of the viatical settlement proceeds by the viator. Rescission, if exercised by the viator, is effective only if both notice of the rescission is given and repayment of all proceeds and any premiums, loans, and loan interest to the viatical settlement provider is made within forty-five days after the end of the rescission period. If the insured dies during the rescission period, the viatical settlement contract is deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans, and loan interest being made to the viatical settlement provider within the rescission period.

(f) That funds must be sent to the viator within three business days after the viatical settlement provider has received the insurer's or group administrator's acknowledgment that ownership of the viaticated policy has been transferred and the beneficiary has been designated;

(g) That entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator, and that the viator may seek assistance from an independent financial adviser;

(h) The following statement: "All medical, financial, or personal information solicited or obtained by a viatical settlement provider or a life insurance producer about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other, may be disclosed as necessary to effect the viatical settlement contract between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

(i) That the insured may be contacted by either the viatical settlement provider or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once each month if the insured has a life expectancy of one year or less.

(2) In addition to the information described in subsection (1) of this section, the disclosure to a viator shall include distribution of a brochure, approved by the commissioner, describing the process of viatical settlements.

(3) No later than the date the viatical settlement contract is signed by all parties, the viatical settlement provider shall provide the viator with at least the following information, displayed conspicuously in the viatical settlement contract or in a separate document signed by the viator and the viatical settlement provider:

(a) The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be acquired pursuant to the viatical settlement contract;

(b) The name, address, and telephone number of the viatical settlement provider;

(c) If a policy to be acquired pursuant to a viatical settlement contract has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the

policy to be acquired pursuant to a viatical settlement contract, the viator shall be informed of the possible loss of coverage on the other lives under the policy and advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement contract;

(d) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy. If known, the viatical settlement provider shall also disclose the availability of additional guaranteed insurance benefits, the dollar amount of accidental death and dismemberment benefits under the policy or certificate, and the viatical settlement provider's interest in those benefits.

(e) The name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator may inspect or receive copies of the relevant escrow or trust agreements or documents.

(4) If the viatical settlement provider transfers ownership or changes the beneficiary of the policy, the viatical settlement provider shall communicate the change in ownership or beneficiary to the insured within twenty days after the change.

Source: L. 2005: Entire part added, p. 1309, § 1, effective January 1, 2006.

10-7-609. General requirements. (1) (a) A viatical settlement provider entering into a viatical settlement contract shall first obtain:

(I) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract; and

(II) A document in which the insured consents to the release of his or her medical records to a viatical settlement provider or insurance producer and, if the policy was issued less than two years after the date of application for a viatical settlement contract, to the insurance company that issued the policy.

(b) The insurer shall respond to a request for verification of coverage submitted by a viatical settlement provider or life insurance producer not later than thirty calendar days after the date the request is postmarked. The request for verification of coverage shall be made on a form approved by the commissioner. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond.

(c) Before or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, acknowledges that the viator has a full and complete understanding of the benefits of the policy, acknowledges that the viator is entering into the viatical settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

(d) If a life insurance producer performs any of the activities required of the viatical settlement provider by this subsection (1), the viatical settlement provider is deemed to have fulfilled the requirements of this section.

(2) Medical information solicited or obtained by a licensee is subject to the applicable provisions of state law relating to confidentiality of medical or protected health information.

(3) A viatical settlement contract entered into in this state shall provide the viator with an unconditional right to rescind the contract before the earlier of thirty calendar days after the date when the viatical settlement contract is executed by all parties or fifteen calendar days after the receipt of the viatical settlement proceeds by the viator. Rescission, if exercised by the viator, is effective only if both notice of the rescission is given and repayment of all proceeds and any premiums, loans, and loan interest to the viatical settlement provider is made within the rescission period. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded if repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the viatical settlement provider is made within forty-five days after the end of the rescission period.

(4) The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment, or beneficiary directly to an independent escrow agent. If the viator erroneously provides the documents directly to the viatical settlement provider, the viatical settlement provider shall immediately notify the escrow agent and shall pay or transfer the proceeds of the viatical settlement contract into an escrow or trust account maintained in a state or federally chartered financial institution whose deposits are insured by the federal deposit insurance corporation within three business days after the date the escrow agent receives the documents, or after the date the viatical settlement provider receives the documents. Upon payment of the viatical settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment, or beneficiary forms to the viatical settlement provider or related provider trust. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company, the escrow agent shall pay the viatical settlement proceeds to the viator.

(5) Failure to tender consideration to the viator for the viatical settlement contract within the time required renders the viatical settlement contract voidable by the viator for lack of consideration until consideration is tendered to and accepted by the viator.

(6) A contact with the insured, for the purpose of determining the health status of the insured by the viatical settlement provider after the viatical settlement contract has been executed, may be made only by the licensed viatical settlement provider or its authorized representatives and is limited to once every three months for insureds with a life expectancy of more than one year, and not more than once each month for insureds with a life expectancy of one year or less. The viatical settlement provider shall explain the procedure for these contacts at the time of entry into the viatical settlement contract. The limitations provided for in this subsection (6) do not apply to a contact with an insured for reasons other than determining the insured's health status. A viatical settlement provider is responsible for the actions of his or her authorized representatives.

Source: L. 2005: Entire part added, p. 1311, § 1, effective January 1, 2006.

10-7-610. Limited purchase in incontestability period. (1) It is a violation of this part 6 for a person to enter into a viatical settlement contract within a two-year period commencing with the date of issuance of the policy unless the viator certifies to the viatical settlement provider that one or more of the following conditions has been met within the two-year period:

(a) The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, if the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four months. The time covered under a group policy shall be calculated without regard to a change in insurance carriers if the coverage has been continuous and under the same group sponsorship.

(b) The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions has been met within the two-year period:

(I) The viator or insured is terminally or chronically ill; or

(II) The viator or insured disposes of his or her ownership interests in a closely held corporation pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued.

(2) Copies of the independent evidence described in paragraph (b) of subsection (1) of this section and documents required must be submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

(3) If the viatical settlement provider submits to the insurer a copy of independent evidence provided for in paragraph (b) of subsection (1) of this section when the viatical settlement provider submits a request to the insurer to effect the transfer of the policy to the viatical settlement provider, the copy is deemed to conclusively establish that the viatical settlement contract satisfies the requirements of this section and the insurer shall respond timely to the request.

Source: L. 2005: Entire part added, p. 1313, § 1, effective January 1, 2006.

10-7-611. Advertising - legislative intent. (1) It is the intent of the general assembly that the purpose of this section is to provide a prospective viator with clear and unambiguous statements in the advertisement of a viatical settlement contract and to assure the clear, truthful, and adequate disclosure of the benefits, risks, limitations, and exclusions of a viatical settlement contract. This purpose is to be accomplished by the establishment of guidelines and standards of permissible and impermissible conduct in the advertising of a viatical settlement contract to assure that a product description is presented in a manner that prevents unfair, deceptive, or misleading advertising and is conducive to accurate presentation and description of a viatical settlement contract through the advertising media and material used by a licensee.

(2) This section applies to an advertising of a viatical settlement contract or a related product or service intended for dissemination in this state, including internet advertising viewed by a person located in this state. Where disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

(3) Each viatical settlement licensee shall establish and at all times maintain a system of control over the content, form, and method of dissemination of an advertisement of its contracts, products, and services. An advertisement, regardless of by whom written, created, designed, or presented, is the responsibility of the licensee, as well as of the individual who created or presented the advertisement. A system of control by the licensee shall include regular notification, at least once a year, to agents and others authorized to disseminate advertisements,

of the requirements and procedures for approval before the use of an advertisement not furnished by the licensee.

(4) An advertisement shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract shall be sufficiently complete and clear so as to avoid deception. It may not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(5) (a) The information required to be disclosed pursuant to the provisions of this section may not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(b) An advertisement may not omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving the public as to the nature or extent of any benefit, loss covered, or state or federal tax consequence. The fact that the viatical settlement contract offered is made available for inspection before consummation of the sale, or that an offer is made to refund the payment if the viator is not satisfied, or that the viatical settlement contract includes a "free look" period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(c) An advertisement may not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved in writing by the insurer.

(d) An advertisement may not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or in any manner an incorrect or improper practice.

(e) The words "free", "no cost", "without cost", "no additional cost", or "at no extra cost", or words of similar import may not be used with respect to a benefit or service unless true. An advertisement may specify the charge for a benefit or service or may state that a charge is included in the payment or use other appropriate language.

(f) (I) Any testimonial, appraisal, or analysis used in an advertisement shall:

(A) Be genuine;

(B) Represent the current opinion of the author;

(C) Be applicable to the viatical settlement contract, product, or service advertised, if any; and

(D) Be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators as to the nature or scope of any testimonial, appraisal, analysis, or endorsement.

(II) In using any testimonial, appraisal, or analysis, the viatical settlement licensee makes as its own all the statements contained in them, and the statements are subject to all the provisions of this section.

(III) If the individual making a testimonial, appraisal, analysis, or endorsement has a financial interest in the viatical settlement provider or related entity as a stockholder, director, officer, employee, or otherwise, or receives a benefit, directly or indirectly, other than required union scale wages, that fact must be disclosed prominently in the advertisement.

(IV) An advertisement may not state or imply that a viatical settlement contract, benefit, or service has been approved or endorsed by a group of individuals, society, association, or other

organization unless that is the fact and unless any relationship between an organization and the licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the licensee or receives payment or other consideration from the licensee for making an endorsement or testimonial, that fact must be disclosed in the advertisement.

(V) If an endorsement refers to benefits received under a viatical settlement contract, all pertinent information shall be retained for a period of five years after its use.

(VI) An advertisement may not contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

(VII) An advertisement may not disparage insurers, viatical settlement providers, insurance producers, policies, services, or methods of marketing.

(VIII) The name of the viatical settlement licensee shall be identified clearly in all advertisements about the licensee or its viatical settlement contract, products, or services, and if any specific viatical settlement contract is advertised, the viatical settlement contract must be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

(IX) An advertisement may not use a trade name, group designation, name of the parent company of a licensee, name of a particular division of the licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the licensee if the advertisement has the capacity or tendency to mislead or deceive as to the true identity of the licensee or to create the impression that a company other than the licensee has any responsibility for the financial obligation under a viatical settlement contract.

(X) An advertisement may not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators into believing that the solicitation is in some manner connected with a government program or agency.

(XI) An advertisement may state that a licensee is licensed in the state where the advertisement appears if it does not exaggerate that fact or suggest or imply that a competing licensee may not be so licensed. The advertisement may ask the audience to consult the licensee's website or contact that state's division of insurance to find out if that state requires licensing and, if so, whether the licensee or any other company is licensed.

(XII) An advertisement may not create the impression that the viatical settlement provider or its financial condition or status; the payment of its claims; or the merits, desirability, or advisability of its viatical settlement contracts are recommended or endorsed by any government entity.

(XIII) The name of the actual licensee shall be stated in all of its advertisements. An advertisement may not use a trade name, group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol, or other device in a manner that has the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity has any responsibility for the financial obligation of the licensee.

(XIV) An advertisement may not, directly or indirectly, create the impression that any division or agency of the state or of the United States government endorses, approves, or favors:

(A) A licensee or its business practices or methods of operation;

(B) The merits, desirability, or advisability of a viatical settlement contract;

(C) Any viatical settlement contract; or

(D) Any policy or life insurance company.

(XV) If the advertiser emphasizes the speed with which the viatical settlement contract occurs, the advertising must disclose the average time frame, from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

(XVI) If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six months.

Source: L. 2005: Entire part added, p. 1314, § 1, effective January 1, 2006.

10-7-612. Fraudulent acts. (1) (a) A person shall not commit a fraudulent viatical settlement act.

(b) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this part 6 or investigations of suspected or actual violations of this part 6.

(c) A person in the business of viatical settlements shall not knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

(2) (a) A viatical settlement contract and an application for a viatical settlement contract, regardless of the form of transmission, shall contain the following statement or a substantially similar statement: "Any person who knowingly presents false information in an application for insurance or viatical settlement contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both."

(b) The lack of a statement as provided for in paragraph (a) of this subsection (2) does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

(3) (a) A person engaged in the business of viatical settlements having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(b) Another person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(4) (a) No civil liability shall be imposed upon, and no cause of action shall arise from the otherwise lawful conduct of, a person who furnishes information concerning suspected, anticipated, or completed fraudulent viatical settlement acts, or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

(I) The commissioner or the commissioner's employees, agents, or representatives;

(II) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(III) A person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees, or representatives;

(IV) The NAIC, the national association of securities dealers, or the North American securities administrators association, or their employees, agents, or representatives, or another regulatory body overseeing life insurance or viatical settlement contracts; or

(V) The insurer that issued the policy covering the life of the insured.

(b) Paragraph (a) of this subsection (4) does not apply to a statement made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that paragraph (a) of this subsection (4) does not apply because the person filing the report or furnishing the information did so with actual malice.

(c) A person identified in paragraph (a) of this subsection (4) is entitled to an award of attorney fees and costs if the person is the prevailing party in a civil cause of action for libel, slander, or another relevant tort arising out of activities in carrying out the provisions of this part 6 and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is substantially justified if it had a reasonable basis in law or fact at the time that it was initiated.

(d) This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in paragraph (a) of this subsection (4).

(e) Paragraph (a) of this subsection (4) does not apply to a person's furnishing information concerning the person's own suspected, anticipated, or completed fraudulent viatical settlement acts or suspected, anticipated, or completed fraudulent insurance acts.

(5) (a) The documents and evidence provided pursuant to subsection (4) of this section or obtained by the commissioner in an investigation of suspected or actual fraudulent viatical settlement acts are privileged and confidential, are not a public record, and are not subject to discovery or subpoena in a civil or criminal action.

(b) Paragraph (a) of this subsection (5) does not prohibit release by the commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

(I) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(II) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts, or to the NAIC; or

(III) At the discretion of the commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(c) Release of documents and evidence pursuant to paragraph (b) of this subsection (5) does not abrogate or modify the privilege granted in paragraph (a) of this subsection (5).

(6) This part 6 does not:

(a) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(b) Prevent or prohibit a person from voluntarily disclosing information concerning fraudulent viatical settlement acts to a law enforcement or regulatory agency other than the division; or

(c) Limit the powers granted elsewhere by the laws of this state to the commissioner or to an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

(7) (a) A viatical settlement provider shall adopt anti-fraud initiatives reasonably calculated to detect, assist in the prosecution of, and prevent fraudulent viatical settlement acts. The commissioner may order or, if a licensee requests, may grant modifications of the following initiatives as necessary to ensure an effective anti-fraud program. The modifications may be more or less restrictive than the initiatives if the modifications may reasonably be expected to accomplish the purpose of this section. Anti-fraud initiatives include:

(I) Fraud investigators, who may be viatical settlement providers or employees or independent contractors of those viatical settlement providers; and

(II) An anti-fraud plan that is submitted to the commissioner. The anti-fraud plan shall include, but not be limited to:

(A) A chart outlining the organizational arrangement of the anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications; and

(B) A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications, a description of the procedures for reporting possible fraudulent viatical settlement acts to the commissioner, and a description of the plan for anti-fraud education and training of underwriters and other personnel.

(b) Anti-fraud plans submitted to the commissioner are privileged and confidential, are not public records pursuant to article 72 of title 24, C.R.S., and are not subject to discovery or subpoena in a civil or criminal action.

Source: L. 2005: Entire part added, p. 1317, § 1, effective January 1, 2006.

10-7-613. Penalties. (1) In addition to the penalties and other enforcement provisions of this part 6, if a person violates the provisions of this part 6 or any rule implementing this part 6, the commissioner may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders as the commissioner determines are necessary to restrain the person from committing the violation.

(2) A person damaged by the acts of a person in violation of this part 6 may bring a civil action against the person committing the violation in a court of competent jurisdiction.

(3) The commissioner may issue a cease-and-desist order to a person who violates any provision of this part 6 or of any rule or order promulgated by, or written agreement entered into with, the commissioner pursuant to this part 6.

(4) When the commissioner finds that an activity in violation of this part 6 presents an immediate danger to the public that requires an immediate final order, the commissioner may issue an emergency cease-and-desist order reciting with particularity the facts underlying the findings. The emergency cease-and-desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for ninety days. If the commissioner begins nonemergency cease-and-desist proceedings, the emergency cease-and-desist order remains

effective absent an order by a court of competent jurisdiction pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S.

(5) In addition to the penalties and other enforcement provisions of this part 6, a person who violates this part 6 is subject to civil penalties of up to ten thousand dollars for each violation pursuant to an order of the commissioner. The commissioner's order may require a person found to be in violation of this part 6 to make restitution to a person aggrieved by violations of this part 6.

(6) (a) A person who violates a provision of this part 6 after the commissioner has issued a cease-and-desist order to the person commits a class 2 misdemeanor and, upon conviction, shall pay restitution to a person aggrieved by the violation. Restitution shall be ordered in addition to a fine or imprisonment, but not instead of a fine or imprisonment.

(b) A person who violates paragraph (a) of this subsection (6), upon conviction, shall be sentenced based on the greater of the value of property, services, or other benefits wrongfully obtained or attempted to be obtained, or the aggregate economic loss suffered by any person as a result of the violation. A person shall be fined not more than:

(I) One hundred thousand dollars or imprisoned for not more than twelve months, or both, if the value of the viatical settlement contract is more than thirty-five thousand dollars;

(II) Twenty thousand dollars or imprisoned for not more than nine months, or both, if the value of the viatical settlement contract is more than two thousand five hundred dollars but not more than thirty-five thousand dollars;

(III) Ten thousand dollars or imprisoned for not more than six months, or both, if the value of the viatical settlement contract is more than five hundred dollars but not more than two thousand five hundred dollars; or

(IV) Three thousand dollars or imprisoned for not more than three months, or both, if the value of the viatical settlement contract is five hundred dollars or less.

(c) In a prosecution under paragraph (a) of this subsection (6), the value of a viatical settlement contract within a six-month period may be aggregated and the defendant charged accordingly in applying the provisions of this section. If two or more offenses are committed by the same person in two or more counties, the accused may be prosecuted in a county in which one of the offenses was committed for all of the offenses aggregated as provided by this section. The statutory limitation period does not begin to run until the insurance company or law enforcement agency is aware of the fraud, but the prosecution may not be commenced later than seven years after the act has occurred.

Source: L. 2005: Entire part added, p. 1320, § 1, effective January 1, 2006.

10-7-614. Unfair trade practices. A violation of this part 6 shall constitute an unfair trade practice pursuant to part 11 of article 3 of this title and be subject to the penalties contained in such part 11.

Source: L. 2005: Entire part added, p. 1322, § 1, effective January 1, 2006.

10-7-615. Rules. (1) The commissioner may:

(a) Promulgate rules implementing this part 6;

(b) Establish standards for evaluating the reasonableness of payments under a viatical settlement contract for a person who is terminally or chronically ill. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy. If the insured is not terminally or chronically ill, a viatical settlement provider shall pay an amount greater than the cash surrender value or accelerated death benefit then available.

(c) Establish appropriate licensing requirements, fees, and standards for continued licensure for a viatical settlement provider and a fee for life insurance producers;

(d) Require a bond or other mechanism for financial accountability for a viatical settlement provider; and

(e) Adopt rules governing the relationship and responsibilities of an insurer and a viatical settlement provider, a life insurance producer, and others in the business of viatical settlements during the period of consideration or effectuation of a viatical settlement contract.

Source: L. 2005: Entire part added, p. 1322, § 1, effective January 1, 2006.

10-7-616. No preemption - Colorado Securities Act - authority of division of securities. Nothing in this part 6 preempts or otherwise limits the provisions of the "Colorado Securities Act", article 51 of title 11, C.R.S., or any rules, orders, policy statements, notices, bulletins, or other interpretations issued by or through the commissioner of securities or the commissioner of securities' designee acting pursuant to the "Colorado Securities Act". Compliance with this part 6 does not constitute compliance with any applicable provision of the "Colorado Securities Act" or any rules, orders, policy statements, notices, bulletins, or other interpretations issued by or through the commissioner of securities or the commissioner of securities' designee acting pursuant to the "Colorado Securities Act".

Source: L. 2005: Entire part added, p. 1323, § 1, effective January 1, 2006.

10-7-617. Application. A viatical settlement provider lawfully transacting business in this state may continue to do so pending approval or disapproval of the person's application for a license as long as the application is filed with the commissioner not later than thirty days after publication by the commissioner of an application form for licensure of viatical settlement providers. If the publication of the application form is prior to January 1, 2006, the filing of the application shall not be later than thirty days after January 1, 2006.

Source: L. 2005: Entire part added, p. 1323, § 1, effective January 1, 2006.

10-7-618. Continuation of business. Notwithstanding any provision of this part 6 to the contrary, a person who has lawfully negotiated viatical settlement contracts between a viator and one or more viatical settlement providers for at least one year immediately prior to January 1, 2006, may continue to negotiate viatical settlements in this state for a period of one year from January 1, 2006, if such person registers with the commissioner on a form prescribed by the commissioner. Such registration form shall be published by the commissioner not later than thirty days after January 1, 2006, and shall require a person registering to evidence that he or she has lawfully negotiated viatical settlement contracts. The form shall also include an

acknowledgment by such person that he or she will operate in accordance with and comply with this part 6.

Source: L. 2005: Entire part added, p. 1323, § 1, effective January 1, 2006.

10-7-619. Viatical settlements cash fund - created. All direct and indirect expenditures of the commissioner and the division in administering this part 6 shall be paid from the viatical settlements cash fund, which fund is hereby created in the state treasury. All fees collected pursuant to this part 6 shall be transmitted to the state treasurer, who shall credit them to the viatical settlements cash fund. All moneys credited to the viatical settlements cash fund shall be used as provided in this section, shall not be deposited in or transferred to the general fund of this state or to any other fund, and shall be subject to annual appropriation by the general assembly for the purpose of defraying the expenses of the commissioner and the division in administering this part 6. All interest derived from the deposit and investment of moneys in the viatical settlements cash fund shall be credited to the viatical settlements cash fund.

Source: L. 2005: Entire part added, p. 1323, § 1, effective January 1, 2006.

10-7-620. Severability. If any provision of this part 6 is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining provisions of this part 6, and to this end the provisions of this part 6 are expressly declared to be severable.

Source: L. 2005: Entire part added, p. 1324, § 1, effective January 1, 2006.

PART 7

INSURABLE INTEREST ACT

10-7-701. Short title. This part 7 shall be known and may be cited as the "Insurable Interest Act".

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 972, § 1, effective May 27.

10-7-702. Definitions. As used in this part 7, unless the context otherwise requires:

(1) "Business entity" means a legal entity, including a joint venture, partnership, corporation, limited liability company, or business trust.

(2) "Person" means any natural person, business entity, association, or trust.

(3) "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state.

(4) "Settlor" means a person who executes a trust instrument, including a person for whom a fiduciary or agent is acting.

(5) "Stranger originated life insurance" means an act, practice, or arrangement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. Stranger originated life insurance practices include cases in which life insurance is purchased with resources or guarantees from or through a person or entity who, at the time of inception, could not lawfully initiate the policy themselves and where, at the time of inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy or the policy benefits to a third party. Trusts that are created to give the appearance of insurable interest and are used to initiate policies for investors violate insurable interest laws and the prohibition on wagering on life. "Stranger originated life insurance" does not include lawful viatical settlement contracts as permitted by part 6 of this article, provided that such contracts are not for the purpose of evading regulation under this article.

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 972, § 1, effective May 27.

10-7-703. Insurance on the life of another. A person shall not procure or cause to be procured or effected a policy upon the life of another individual unless the benefits under the policy are payable to the insured, to the personal representative of the insured's estate, or to a person having, at the time the policy is issued, an insurable interest in the individual insured.

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 973, § 1, effective May 27.

10-7-704. Insurable interest. (1) An insurable interest, with reference to insurance on the life of another, exists only as follows:

(a) An individual has an insurable interest in the life of another person in whom the individual has a substantial interest engendered by love and affection in the continuation of the life of the insured and who are:

(I) Related within the fifth degree or closer, as measured by the civil law system of determining degrees of relation, either by blood or marriage to the insured;

(II) Stepchildren of the insured or their descendants; or

(III) Individuals who are designated as beneficiaries of insurance policies for life insurance coverage on the life of the insured under a designated beneficiary agreement executed pursuant to article 22 of title 15, C.R.S.;

(b) An individual has an insurable interest in the life of another person if such individual has a lawful and substantial interest in the continued life of the insured, as distinguished from an interest that would arise only from, or would be enhanced in value by, the death of the individual insured;

(c) An individual party to a contract for the purchase or sale of an interest in a business entity has an insurable interest in the life of each other individual party to the contract, but only for the purpose of carrying out the intent and purpose of the contract;

(d) A trustee of a trust has an insurable interest in the life of an insured under a life insurance policy as provided in section 15-5-114;

(e) A guardian, trustee, or other fiduciary, acting in a fiduciary capacity, has an insurable interest in the life of any person for whose benefit the fiduciary holds property and in the life of any other individual in whose life the person has an insurable interest so long as the life

insurance proceeds are used primarily for the benefit of persons having an insurable interest in the life of the insured;

(f) An organization described in section 170 (c) of the federal "Internal Revenue Code of 1986", as amended, has an insurable interest in the life of any person who consents in writing to the organization's ownership or purchase of that insurance pursuant to section 10-7-115;

(g) A trustee, sponsor, or custodian of assets held in any plan governed by the "Employee Retirement Income Security Act of 1974", 29 U.S.C. sec. 1001 et seq., or in any other retirement or employee benefit plan, has an insurable interest in the life of any participant in the plan, but only if consent is obtained in writing from the participant before the insurance is purchased. An employer, trustee, sponsor, or custodian may not retaliate or take adverse action against a participant who does not consent to the issuance of insurance on the participant's life.

(h) A business entity has an insurable interest in the life of any of the owners, directors, officers, partners, or managers of the business entity or any affiliate or subsidiary of the business entity, or key employees or key persons of the business entity, affiliate, or subsidiary, but only if consent is obtained in writing from the key employees or key persons before the insurance is purchased. The business entity, affiliate, or subsidiary may not retaliate or take adverse action against any key employee or key person who does not consent to the issuance of insurance on the key employee or key person's life. For purposes of this paragraph (h), "key employee" or "key person" means an individual whose position or compensation is described in section 101 (j)(2)(A)(ii) of the federal "Internal Revenue Code of 1986", as amended.

(i) A financial institution or other person to whom a debt is owed, whether for the purposes of premium financing or otherwise, has an insurable interest in the life of the borrower or any of the owners, directors, officers, partners, or managers of the borrower; key employees, guarantors, or key persons of the borrower; or any of the foregoing of an affiliate or a guarantor of the borrower, but only if consent is obtained in writing from such persons before the insurance is purchased; except that such insurable interest is limited to the amount of the debt owed plus reasonable interest and service charges. The proceeds payable upon the death of an insured in excess of the total outstanding debt owed shall be paid to the estate of the individual insured.

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 973, § 1, effective May 27. **L. 2018:** (1)(d) amended, (SB 18-180), ch. 169, p. 1192, § 3, effective January 1, 2019.

10-7-705. Insured's own life. An individual has an insurable interest in the individual's own life, and an individual of competent legal capacity who procures or effects a policy on the individual's own life may designate any person as the beneficiary and, unless the individual elects an irrevocable beneficiary designation, change the beneficiary at any time thereafter.

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 975, § 1, effective May 27.

10-7-706. Reliance on statements. An insurer is entitled to rely upon all reasonable statements, declarations, and representations made by an applicant for life insurance relative to the existence of an insurable interest. No insurer incurs legal liability, except as set forth in the policy, by virtue of untrue statements, declarations, or representations relied upon in good faith by the insurer.

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 975, § 1, effective May 27.

10-7-707. Consent of insured. (1) A policy upon the life of an individual, other than a policy of noncontributory group life insurance, shall not be effected unless, at or before the time the policy is effectuated, the individual insured, having legal capacity to contract, applies for or consents in writing to the policy and its terms. Consent may be given by another person in the following cases:

(a) A spouse may consent to insurance on the other spouse;

(b) A parent or a person having legal custody of a minor may consent to the issuance of a policy on a dependent child;

(c) A court-appointed guardian of a person may consent to the issuance of a policy on the person under guardianship;

(d) A court-appointed conservator of a person's estate may consent to the issuance of a policy on the person whose estate is under conservatorship;

(e) An attorney-in-fact may consent to the issuance of a policy on the person that appointed the attorney-in-fact for the limited purpose of replacing one or more policies with one or more new policies if, as the result of the replacement, the aggregate amount of life insurance on the person remains the same or decreases;

(f) A trustee of a revocable trust may consent to the issuance of a policy on the life of a settlor of the trust; and

(g) A court of general jurisdiction may give consent to the issuance of a policy upon a showing of facts that the court considers sufficient to justify the issuance of the policy.

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 975, § 1, effective May 27.

10-7-708. Prohibited practices. (1) It is unlawful for any person to procure, or cause to be procured or effected, a policy in violation of section 10-7-703. Such conduct is an unfair or deceptive act or practice pursuant to section 10-3-1104.

(2) It is unlawful for any person to engage in stranger originated life insurance or otherwise wager on life. Such conduct is an unfair or deceptive practice pursuant to section 10-3-1104.

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 976, § 1, effective May 27.

10-7-709. Actions to recover death benefits. If the beneficiary, assignee, or other payee received the death benefits under a life insurance policy procured or effected in violation of this article, the personal representative of the insured's estate or other lawfully acting agent may maintain an action to recover the death benefits from the person receiving them.

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 976, § 1, effective May 27.

10-7-710. Legitimate insurance transactions. (1) Except where a life insurance policy is procured or effected in violation of section 10-7-708, nothing in this article prevents:

(a) An owner of a policy, whether or not the owner of the policy is also the subject of the insurance, from entering into a viatical settlement contract;

(b) Any person from soliciting a person to enter into a viatical settlement contract; or

(c) An owner or beneficiary from enforcing the payment of all benefits and proceeds of the policy obtained under a viatical settlement contract.

Source: L. 2011: Entire part added, (SB 11-182), ch. 227, p. 976, § 1, effective May 27.

PART 8

UNCLAIMED LIFE INSURANCE BENEFITS ACT

10-7-801. Short title. The short title of this part 8 is the "Unclaimed Life Insurance Benefits Act".

Source: L. 2019: Entire part added, (SB 19-088), ch. 110, p. 463, § 4, effective July 1, 2020.

10-7-802. Definitions. As used in this part 8, unless the context otherwise requires:

(1) "Contract" means an annuity contract. The term does not include an annuity used to fund an employment-based retirement plan or program if:

(a) The insurer does not perform the record-keeping services; or

(b) The insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

(2) "Death master file" means the United States social security administration death master file or other databases or service that is at least as comprehensive as the United States social security administration death master file for determining that an individual reportedly has died.

(3) "Death master file match" means a search of the death master file that results in a match of the social security number or the name and date of birth of an insured, annuity owner, or retained asset account holder.

(4) "Knowledge of death" means:

(a) Receipt of an original or valid copy of a certified death certificate; or

(b) A death master file match validated by the insurer in accordance with section 10-7-803 (2)(a)(I).

(5) "Policy" means any policy or certificate of life insurance that provides a death benefit. The term does not include:

(a) A policy or certificate of life insurance that provides a death benefit under an employee benefit plan:

(I) Subject to the federal "Employee Retirement Income Security Act of 1974", 29 U.S.C. sec. 1001 et seq., as amended; or

(II) Under any federal employee benefit program;

(b) A policy or certificate of life insurance that is used to fund a pre-need funeral contract or prearrangement;

(c) A policy or certificate of credit life or accidental death insurance; or

(d) A policy issued to a group master policyholder for which the insurer does not provide record-keeping services.

(6) "Record-keeping services" means those services which the insurer has agreed with a group policy or contract customer to be responsible for obtaining, maintaining, and administering in its own or its agents' systems information about each individual insured under an insured's group insurance contract, or a line of coverage thereunder, including at least the following information:

(a) Social security number or name and date of birth;

(b) Beneficiary designation information;

(c) Coverage eligibility;

(d) Benefit amount; and

(e) Premium payment status.

(7) "Retained asset account" means a mechanism whereby the settlement of proceeds payable under a policy or contract is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, if those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

Source: L. 2019: Entire part added, (SB 19-088), ch. 110, p. 463, § 4, effective July 1, 2020. **L. 2020:** (5)(a)(I) amended, (HB 20-1402), ch. 216, p. 1043, § 14, effective June 30.

10-7-803. Insurers - duty to compare names of insureds with death master file and to locate beneficiaries. (1) An insurer shall make a good faith effort to determine the death of an insured upon receipt of knowledge of death.

(2) An insurer shall perform a comparison of its insureds' in-force policies, contracts, and retained asset accounts against a death master file, on at least a semiannual basis, by using the full death master file once and thereafter using the death master file update files for future comparisons to identify potential matches of its insureds. For those potential matches identified as a result of a death master file match, the insurer shall do the following:

(a) Within ninety days of a death master file match, the insurer shall:

(I) Complete a good faith effort, which must be documented by the insurer, to confirm the death of the insured or retained asset account holder against other available records and information; and

(II) Determine whether benefits are due in accordance with the applicable policy or contract, and, if benefits are due in accordance with the applicable policy or contract:

(A) Use good faith efforts, which shall be documented by the insurer, to locate the beneficiary or beneficiaries; and

(B) Provide the appropriate claims forms or instructions to the beneficiary or beneficiaries to make a claim including the need to provide an official death certificate, if applicable under the policy or contract.

(b) With respect to group life insurance, the insurer shall confirm the possible death of an insured if the insurer maintains at least the following information of those covered under a policy or certificate:

(I) Social security number or name and date of birth;

(II) Beneficiary designation information;

(III) Coverage eligibility;

(IV) Benefit amount; and

(V) Premium payment status.

(c) An insurer shall implement procedures to account for:

(I) Common nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names;

(II) Compound last names, maiden or married names, and hyphens, blank spaces, or apostrophes in last names;

(III) Transposition of the "month" and "date" portions of the date of birth; and

(IV) Incomplete social security numbers.

(d) To the extent permitted by law, the insurer may disclose minimum necessary personal information about the insured or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer with locating the beneficiary or person otherwise entitled to payment of the claims proceeds.

(3) An insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

(4) The benefits from a policy, contract, or a retained asset account, plus any applicable accrued contractual interest shall first be payable to the designated beneficiaries or owners and in the event said beneficiaries or owners cannot be found, shall be transferred to the Colorado administrator as unclaimed property pursuant to the "Revised Uniform Unclaimed Property Act", article 13 of title 38.

(5) An insurer that fails to comply with this section is subject to the civil penalties in accordance with section 10-1-310. A private cause of action for a violation of this section is not permitted.

Source: L. 2019: Entire part added, (SB 19-088), ch. 110, p. 464, § 4, effective July 1, 2020.

COVERCOLORADO

ARTICLE 8

CoverColorado

Cross references: For workers' compensation, see articles 40 to 47 of title 8; for the crime of abuse of health insurance by health care providers, see § 18-13-119; for provisions concerning health care coverage, see article 16 of this title 10.

PART 1

GENERAL

10-8-101 to 10-8-126. (Repealed)

Source: L. 92: Entire part repealed, p. 1728, § 22, effective July 1.

Editor's note: This part 1 was numbered as article 10 of chapter 72, C.R.S. 1963. For amendments to this part 1 prior to its repeal in 1992, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions of this part 1 were relocated to parts 1 and 2 of article 16 of this title. For the location of specific provisions, see the editor's notes following each section in said parts 1 and 2 and the comparative tables located in the back of the index.

PART 2

STATE EMPLOYEES' AND OFFICIALS' GROUP INSURANCE

10-8-201 to 10-8-219. (Repealed)

Source: L. 94: Entire part repealed, p. 1137, § 4, effective May 19.

Editor's note: This part 2 was numbered as article 22 of chapter 72, C.R.S. 1963. For amendments to this part 2 prior to its repeal in 1994, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions of this part 2 were relocated to part 6 of article 50 of title 24. For the location of specific provisions, see the editor's notes following each section in said part 6.

PART 3

REQUIRED HEALTH INSURANCE BENEFITS FOR ALCOHOLISM TREATMENT

10-8-301. (Repealed)

Source: L. 92: Entire part repealed, p. 1728, § 22, effective July 1.

Editor's note: This part 3 was added in 1975 and was not amended prior to its repeal in 1992. For the text of this part 3 prior to 1992, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of the volume. The provisions of this part 3 were relocated to part 1 of article 16 of this title. For the location of specific provisions, see the editor's notes following each section in said part 1 and the comparative tables located in the back of the index.

PART 4

REQUIRED HEALTH INSURANCE BENEFITS FOR HOME HEALTH SERVICES AND HOSPICE CARE

10-8-401. (Repealed)

Source: L. 92: Entire part repealed, p. 1728, § 22, effective July 1.

Editor's note: This part 4 was added in 1984. For amendments to this part 4 prior to its repeal in 1992, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions of this part 4 were relocated to part 1 of article 16 of this title. For the location of specific provisions, see the editor's notes following each section in said part 1 and the comparative tables located in the back of the index.

PART 5

COVERCOLORADO

10-8-501 to 10-8-537. (Repealed)

Editor's note: (1) This part 5 was added in 1990. For amendments to this part 5 prior to its repeal in 2015, consult the 2014 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

(2) Section 10-8-537 provided for the repeal of this part 5, effective March 31, 2015. (See L. 2013 p. 1970.)

PART 6

SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY PROGRAM ACT

10-8-601 to 10-8-607. (Repealed)

Source: L. 2004: Entire part repealed, p. 1011, § 23, effective August 4.

Editor's note: This part 6 was added in 1992. For amendments to this part 6 prior to its repeal in 2004, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

FRANCHISE INSURANCE

ARTICLE 9

Franchise Insurance

10-9-101 to 10-9-104. (Repealed)

Source: L. 95: Entire article repealed, p. 197, § 9, effective April 13.

Editor's note: This article was numbered as article 21 of chapter 72, C.R.S. 1963. For amendments to this article prior to its repeal in 1995, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

CREDIT INSURANCE

ARTICLE 10

Credit Insurance

10-10-101. Short title. This article shall be known and may be cited as the "Credit Insurance Act".

Source: L. 69: p. 536, § 2. **C.R.S. 1963:** § 72-28-2. **L. 92:** Entire section amended, p. 1569, § 81, effective May 20.

10-10-102. Legislative declaration. The purpose of this article is to promote the public welfare by regulating credit insurance. Nothing in this article is intended to prohibit or discourage reasonable competition. The provisions of this article shall be liberally construed.

Source: L. 69: p. 536, § 1. **C.R.S. 1963:** § 72-28-1. **L. 92:** Entire section amended, p. 1569, § 82, effective May 20.

10-10-103. Definitions. As used in this article, unless the context otherwise requires:

(1) "Commissioner" means the commissioner of insurance of Colorado.

(2) "Credit insurance" means insurance on a debtor to provide indemnity for payments or loan balance, or any combination thereof, becoming due on a specific loan or other credit transaction upon the occurrence of a contingency for which insurance is obtained.

(3) (Deleted by amendment, L. 92, p. 1569, § 83, effective May 20, 1992.)

(4) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of any such lender, vendor, or lessor, and an affiliate, associate, or subsidiary of any of them, or any director, officer, or employee of any of them, or any other person in any way associated with any of them.

(5) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction.

(6) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

(7) "Truncated coverage" means credit insurance that provides a term of insurance coverage for a period that is shorter than the full term of the indebtedness remaining at the time the insurance coverage is elected. The term does not include credit insurance coverage that terminates on attainment of a specific age.

Source: L. 69: p. 536, § 4. **C.R.S. 1963:** § 72-28-4. **L. 92:** (2) and (3) amended, p. 1569, § 83, effective May 20. **L. 2000:** (7) added, p. 151, § 1, effective August 2.

10-10-104. Application of article. All insurance in connection with loans or other credit transactions shall be subject to the provisions of this article. Insurance shall not be subject to the provisions of this article where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

Source: L. 69: p. 536, § 3. **C.R.S. 1963:** § 72-28-3. **L. 85:** Entire section amended, p. 302, § 14, effective May 10. **L. 92:** Entire section amended, p. 1569, § 84, effective May 20. **L. 2000:** Entire section amended, p. 168, § 1, effective August 2.

10-10-105. Forms of credit life insurance and credit accident and health insurance. (Repealed)

Source: L. 69: p. 537, § 5. **C.R.S. 1963:** § 72-28-5. **L. 86:** (2) added, p. 593, § 1, effective March 26. **L. 92:** Entire section repealed, p. 1569, § 85, effective May 20.

10-10-106. Amount of credit insurance. (1) The initial amount of credit insurance shall not exceed the total amount repayable under the contract of indebtedness and, where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

(2) Notwithstanding the provisions of subsection (1) of this section, insurance on agricultural credit transaction commitments, not exceeding one year in duration, may be written up to the amount of the loan commitment on a nondecreasing or level term plan.

(3) Notwithstanding any other provision of this section, insurance on educational credit transaction commitments may be written for the amount of the portion of such commitment that has not been advanced by the creditor.

(4) The total amount of periodic indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness; and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments.

Source: L. 69: p. 537, § 6. **C.R.S. 1963:** § 72-28-6. **L. 92:** (1) amended, p. 1570, § 86, effective May 20.

10-10-107. Term of credit insurance. The term of any credit insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor; except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than thirty days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund

or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than thirty days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor, unless the debtor has agreed in writing. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance is issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section 10-10-110.

Source: L. 69: p. 537, § 7. **C.R.S. 1963:** § 72-28-7. **L. 83:** (1)(b) amended, p. 512, § 1, effective May 16. **L. 92:** Entire section amended, p. 1570, § 87, effective May 20.

10-10-108. Provisions of policies and certificates of insurance - disclosure to debtors. (1) All credit insurance shall be evidenced by an individual policy or, in the case of group insurance, by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(2) Each individual policy or group certificate of credit insurance shall, in addition to other requirements of law, set forth:

(a) The name and home office address of the insurer;

(b) The name of the debtor or, in the case of a certificate under a group policy, the identity by name, or otherwise, of the debtor;

(c) The premium or amount of payment, if any, by the debtor separately for credit insurance;

(d) A description of the coverage, including the amount and term thereof, and any exceptions, limitations, and restrictions, and it shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance exceeds the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.

(3) Said individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred, except as provided in subsection (4) of this section.

(4) (a) If said individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor, shall be delivered to the debtor at the time such indebtedness is incurred, setting forth:

(I) The name and home office address of the insurer;

(II) The name of the debtor;

(III) The premium or amount of payment by the debtor, if any, separately for credit insurance;

(IV) The amount, term, and a brief description of the coverage provided.

(b) The copy of the application for, or notice of, proposed insurance shall also refer exclusively to insurance coverage and shall be separate and apart from the loan, sale, or other credit statement of account, instrument, or agreement unless the information required by this subsection (4) is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. Said

application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in section 10-10-107.

(c) If the named insurer does not accept the risk, the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and, if the amount of premium is less than that set forth in the notice of proposed insurance, an appropriate refund shall be made.

Source: L. 69: p. 538, § 8. **C.R.S. 1963:** § 72-28-8. **L. 92:** (1), (2), and (4)(a)(III) amended, p. 1570, § 88, effective May 20.

10-10-109. Filing form certification - filing of rating data - withdrawal of forms. (1) All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery in this state shall be certified, and the schedules of premium rates pertaining thereto shall be filed with the commissioner pursuant to subsections (3), (3.5), and (4) of this section.

(2) Repealed.

(2.5) (a) For credit insurance directly written by a state or national bank, an insurer may, by form number, elect to be subject to and have its premium rate or schedule of premium rates determined pursuant to paragraph (b) or paragraph (c) of this subsection (2.5). For credit insurance not directly written by a state or national bank, an insurer shall have its premium rate or schedule of premium rates determined by paragraph (c) of this subsection (2.5).

(b) A premium rate or schedule of premium rates shall be deemed reasonable for all purposes under this article if the rate or schedule produces, or reasonably may be expected to produce, a ratio of incurred claims to earned premium of not less than forty percent.

(c) (I) Except for credit insurance directly written by a state or national bank where the insurer has elected to be subject to paragraph (b) of this subsection (2.5), an insurer's premium rate or schedule of premium rates shall be reasonable in relation to the benefits provided and shall not be excessive, inadequate, nor unfairly discriminatory. The commissioner may establish rates that may be used by any insurer without filing. In establishing such rates, the commissioner shall consider and provide for the following component rating elements:

(A) Actual and expected loss experience;

(B) General and administrative expenses;

(C) Loss settlement and adjustment expenses;

(D) Reasonable creditor compensation;

(E) Investment income;

(F) The manner in which premiums are charged;

(G) Other acquisition costs;

(H) Reserves;

(I) Taxes;

(J) Regulatory license fees and fund assessments;

(K) Reasonable insurer profit; and

(L) Other relevant data consistent with generally accepted actuarial standards.

(II) The commissioner has the authority to promulgate rules to assure that the premium rates are reasonable in relation to the benefits provided, including the authority to regulate the compensation component of the premium rates and to limit the type and kind of benefits to

which the rates shall apply. The commissioner shall work with the regulated community in the development of the component rating elements. Each credit insurer that receives combined direct credit insurance premiums in this state in the amount of one hundred thousand dollars or more shall be subject to an administrative assessment of not more than one thousand five hundred dollars per insurer annually to provide the division of insurance with funds to perform duties required by this paragraph (c).

(3) All insurers providing credit insurance that are authorized by the commissioner to conduct business in Colorado shall submit to the commissioner:

(a) An annual report listing any policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders issued or delivered in this state. Such listing shall be submitted on or before July 15, 2000, and on or before July 1 of each subsequent year. Each annual report shall include a certification by an officer of the organization that, to the best of the officer's knowledge, each policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider in use complies with Colorado law.

(b) A list of new policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders. Such list shall also include a certification by an officer of the organization that, to the best of the officer's knowledge, each policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider in use complies with Colorado law.

(3.5) If an insurer elects to file pursuant to paragraph (c) of subsection (2.5) of this section, commencing July 1, 2002, the insurer shall offer only component rating for credit insurance premiums pursuant to subsection (2.5) of this section for all new policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery and phase in all existing creditor accounts to component rating accounts by no later than July 1, 2003.

(4) The commissioner shall have the power to examine and investigate insurers authorized to conduct business within Colorado to determine whether credit insurance policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders comply with the certification made by the insurer's officer and with Colorado law. The commissioner may promulgate rules regarding the elements necessary in an insurer's certification of compliance with Colorado law.

(5) and (6) (Deleted by amendment, L. 2000, p. 467, § 7, effective August 2, 2000.)

(7) Any order or final determination of the commissioner under the provisions of this section shall be subject to judicial review.

(8) (a) If, after an examination or investigation of an insurer, the commissioner has cause to believe that such insurer or any rate, rating schedule, rating plan, or rating system made or used by the insurer does not comply with applicable requirements, the commissioner shall give notice in writing to such insurer, stating in the notice in what manner and to what extent such noncompliance is alleged to exist and specifying a reasonable time, not less than ten days after the date of receipt of such notice, by which such noncompliance shall be corrected.

(b) If the commissioner has good cause to believe that an insurer's noncompliance is willful or, if within the period prescribed by the commissioner in the notice issued in accordance with paragraph (a) of this subsection (8), the insurer does not either make such changes as may be necessary to correct the noncompliance specified by the commissioner or establish to the

satisfaction of the commissioner that such specified noncompliance does not exist, the commissioner may hold a public hearing in accordance with section 24-4-105, C.R.S., on the subject of the noncompliance.

(c) (I) If, after a public hearing, the commissioner finds that any rate violates the applicable provisions of this title, the commissioner may issue an order to the insurer specifying in what respects such violation exists and stating when, within a reasonable period of time, the further use of such rate or rating system by such insurer or rating organization in contracts of insurance made after such time shall be prohibited. In such order, the commissioner may require a refund to the policyholder in an amount equal to the excess premium plus a maximum of eighteen percent interest. The amount of the refund, plus interest, shall be computed from the effective date of the rate used on the individual policyholder contract to the commencement date of the hearing on the rate. Interest shall be computed as simple interest per annum.

(II) In addition to any other remedies or penalties provided by law, the commissioner may suspend or revoke, in whole or in part, the certificate of authority of any insurer that fails to comply with an order of the commissioner within the time specified in such order. The commissioner shall not suspend or revoke the license or certificate of authority for failure to comply with an order until the time prescribed for an appeal of the order has expired, or, if an appeal has been taken, until such order has been affirmed. The commissioner may determine when a suspension or revocation of a certificate of authority shall become effective. An order of suspension shall remain in effect for the period fixed by the commissioner unless the commissioner modifies or rescinds such suspension or until the order upon which such suspension is based is modified, rescinded, or reversed. No license shall be suspended or revoked except pursuant to a written order of the commissioner, stating the commissioner's findings, made after a hearing held upon not less than ten days' written notice to such insurer specifying the alleged violation.

(d) (I) If, after a public hearing, the commissioner finds that the violation of any of the applicable provisions of this title was willful, the commissioner may suspend or revoke, in whole or in part, the certificate of authority of such insurer.

(II) If a failure to comply with an order of the commissioner within the time specified in such order is willful, the insurer shall be liable to the state in an amount not to exceed five thousand dollars for such failure. The commissioner shall collect such amount and may bring a civil action in the name of the people of the state of Colorado to enforce collection. Such penalty may be in addition to the remedy provided in subparagraph (I) of this paragraph (d). All moneys collected by the commissioner shall be paid into the general fund.

(e) Any finding, determination, rule, ruling, or order made by the commissioner pursuant to this subsection (8) is subject to judicial review by the court of appeals. Such review shall be performed in accordance with the provisions of section 24-4-106 (11), C.R.S.

Source: L. 69: p. 539, § 9. **C.R.S. 1963:** § 72-28-9. **L. 92:** (2) and (6) amended, p. 1571, § 89, effective May 20. **L. 2000:** (1), (2), (3), (4), (5), and (6) amended, p. 467, § 7, effective August 2. **L. 2001:** (2.5) added, p. 891, § 2, effective June 1; (1) amended, (2) repealed, and (3.5) and (8) added, pp. 892, 891, §§ 1, 3, effective July 1, 2002.

Cross references: For the legislative declaration contained in the 2000 act amending subsections (1), (2), (3), (4), (5), and (6), see section 1 of chapter 135, Session Laws of Colorado 2000.

10-10-110. Premiums and refunds. (1) (a) If an insurer has elected to file pursuant to section 10-10-109 (2.5)(b), the insurer may revise its schedules of premium rates from time to time and shall file such revised schedules with the commissioner. No insurer shall issue any credit insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the commissioner.

(b) If an insurer has elected to file pursuant to section 10-10-109 (2.5)(c), the insurer may file with the commissioner and use any premium rate or schedule of premium rates that is less than or equal to the premium rate established by the commissioner. Insurers shall not use premium rates higher than the premium rates established by the commissioner.

(2) (a) Upon prepayment in full of the indebtedness, all credit insurance issued on such indebtedness shall terminate.

(b) An insurer, upon receiving notice pursuant to section 5-4-108 (2), C.R.S., that a refund or credit of unearned premiums on insurance issued under this article is required by section 5-4-108 (1), C.R.S., shall make the appropriate refund or credit to the person entitled thereto within thirty days of receipt of such notice. The formula to be used in computing the refund or credit shall be filed with and approved by the commissioner. No refund of less than one dollar need be made.

(3) If a creditor requires a debtor to make any payment for credit insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

(4) The amount charged to a debtor for any credit insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(5) Nothing in this article shall be construed to authorize any payments for insurance now prohibited under any statute, or rule thereunder, governing credit transactions.

Source: L. 69: p. 540, § 10. **C.R.S. 1963:** § 72-28-10. **L. 88:** (2) R&RE, p. 340, § 2, effective July 1. **L. 92:** (1), (3), and (4) amended, p. 1572, § 90, effective May 20. **L. 2001:** (1) amended, p. 894, § 4, effective July 1, 2002.

10-10-111. Issuance of policies. All policies of credit insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein and shall be issued only through holders of licenses or authorizations issued by the commissioner.

Source: L. 69: p. 540, § 11. **C.R.S. 1963:** § 72-28-11. **L. 92:** Entire section amended, p. 1572, § 91, effective May 20.

10-10-112. Claims. (1) All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(2) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions or upon direction of such claimant to one specified.

(3) No plan or arrangement shall be used whereby any person, firm, or corporation, other than the insurer or its designated claim representative, is authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims, but a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

Source: L. 69: p. 540, § 12. **C.R.S. 1963:** § 72-28-12.

10-10-113. Existing insurance - choice of insurer. When credit insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

Source: L. 69: p. 541, § 13. **C.R.S. 1963:** § 72-28-13. **L. 92:** Entire section amended, p. 1572, § 92, effective May 20.

10-10-114. Enforcement. The commissioner may, after notice and hearing, issue such rules and regulations as he deems appropriate for the supervision of this article. If the commissioner finds that there has been a violation of this article or any rules or regulations issued pursuant thereto, and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the commissioner, he shall set forth the details of his findings, together with an order for compliance by a specified date. Such order is binding on the insurer or other person authorized or licensed by the commissioner on the date specified, unless sooner withdrawn by the commissioner or a stay thereof has been ordered by a court of competent jurisdiction.

Source: L. 69: p. 541, § 14. **C.R.S. 1963:** § 72-28-14.

10-10-115. Judicial review. Any party to the proceeding affected by an order of the commissioner shall be entitled to judicial review by the court of appeals by following the procedure set forth in section 24-4-106 (11), C.R.S.

Source: L. 69: p. 541, § 15. **C.R.S. 1963:** § 72-28-15. **L. 92:** Entire section amended, p. 1572, § 93, effective May 20.

10-10-116. Penalties. In addition to any other penalty provided by law, any person, firm, or corporation which violates an order of the commissioner after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the division of insurance a sum not to exceed two hundred fifty dollars which may be recovered in a civil action; except that, if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed one thousand dollars. The commissioner, in his discretion, may

revoke or suspend the insurance license or certificate of authority of the person, firm, or corporation guilty of such violation. Such order for suspension or revocation shall be upon notice and hearing and shall be subject to judicial review as provided in section 10-10-115.

Source: L. 69: p. 541, § 16. **C.R.S. 1963:** § 72-28-16.

10-10-117. Insurance expense not computed as cost of loan. In connection with insurance which is permitted under this article, the premium and any gain or advantage to the creditor, or to any employee, affiliate, or associate of the creditor, from such insurance or its sale shall not be deemed to be an additional or further interest, discount, or charge, and the creditor may receive commissions on the premium paid for such insurance if the creditor or an employee of the creditor is a duly licensed insurance broker or agent under the insurance laws of the state of Colorado.

Source: L. 69: p. 541, § 17. **C.R.S. 1963:** § 72-28-17.

Cross references: Agents and brokers referenced in this section are referred to as insurance producers, pursuant to part 4 of article 2 of this title 10. (See chapter 257, Session Laws of Colorado 1993.)

10-10-118. Charge accounts. Nothing in this article shall be construed to permit credit insurance to be required by any creditor for revolving charge accounts or any other charge accounts for the purchase of goods or services.

Source: L. 69: p. 541, § 18. **C.R.S. 1963:** § 72-28-18. **L. 92:** Entire section amended, p. 1572, § 94, effective May 20.

10-10-119. Truncated coverage. (1) If the debtor elects truncated coverage, at the time of election the creditor shall inform the debtor in writing of the term of the insurance coverage and that the coverage will terminate prior to the scheduled maturity date of the indebtedness.

(2) A group certificate or individual policy providing truncated credit insurance coverage shall disclose the term of the truncated insurance coverage and specify that the term of insurance coverage will terminate prior to the scheduled maturity date of the indebtedness. The termination disclosure shall appear in prominent type on the first page of the group certificate or individual policy.

Source: L. 2000: Entire section added, p. 151, § 2, effective August 2.

TITLE INSURANCE

ARTICLE 11

Title Insurance

Law reviews: For article, "1987 ALTA Insurance Revisions: An Owner's Perspective -- Parts I and II", see 17 Colo. Law. 445 and 627 (1988).

PART 1

TITLE INSURANCE CODE

10-11-101. Short title. This article shall be known and may be cited as the "Title Insurance Code of Colorado".

Source: L. 69: p. 520, § 1. **C.R.S. 1963:** § 72-26-1.

10-11-102. Definitions. As used in this article 11, unless the context otherwise requires:

(1) "Affiliate" or "subsidiary" means a person who directly or indirectly, through one or more intermediaries:

(a) Controls a title insurance agent or title insurance company;

(b) Is controlled by a title insurance company; or

(c) Is under common control with a title insurance agent or title insurance company.

(1.3) "Affiliated business arrangement" means an arrangement in which:

(a) (I) A settlement producer or an associate of such producer has either an affiliate relationship with, or a direct beneficial ownership interest of more than one percent in, a title insurance company or title insurance agent; or

(II) A title insurance company or a title insurance agent who has either an affiliate relationship with, or a direct beneficial ownership interest of more than one percent in a settlement producer; and

(b) (I) Either the settlement producer or the agent of the settlement producer directly or indirectly refers settlement service business to that title insurance company or title insurance agent or affirmatively influences the selection of that title insurance company or title insurance agent; or

(II) Either the title insurance company or the title insurance agent directly or indirectly refers settlement services business to a settlement producer or associate or affirmatively influences the selection of the settlement producer or associate.

(1.5) "Alien title insurance company" means a title insurance company incorporated or organized under the laws of a foreign nation, or of any province or territory thereof, not included under the definition of a foreign title insurance company.

(2) "Applicants for insurance" includes all those, whether or not a prospective insured, who from time to time apply to a title insurance company, or to its agent, for title insurance and who at the time of such application are not agents for a title insurance company.

(2.5) "Associate" means a person who has one or more of the following relationships with a person in a position to refer settlement service business:

(a) A spouse, parent, or child of such person;

(b) A corporation or business entity that controls, is controlled by, or is under common control with such person;

(c) An employer, officer, director, partner, franchiser, or franchisee of such person; or

(d) Anyone who has an agreement, arrangement, or understanding with such person, the purpose or substantial effect of which is to enable the person in a position to refer settlement service business to benefit financially from referrals of such business.

(3) The "business of title insurance" means the making or proposing to make, as insurer, guarantor, or surety, of any contract or policy of title insurance; or the transacting or proposing to transact, as insurer, guarantor, or surety, any phase of title insurance, including solicitation, negotiation preliminary to execution, execution of a contract of title insurance, and transacting matters subsequent to the execution of the contract and arising out of it, including reinsurance, and the performance of closing and settlement services by a title insurance company or title insurance agent in conjunction with the issuance of any contract or policy of title insurance.

(3.5) "Closing and settlement services" means providing services for the benefit of all necessary parties in connection with the sale, leasing, encumbering, mortgaging, creating a secured interest in and to real property, and the receipt and disbursement of money in connection with any sale, lease, encumbrance, mortgage, or deed of trust.

(3.6) Repealed.

(3.7) "Gap coverage" means insuring, guaranteeing, or indemnifying owners of real property, or others interested therein, against loss or damage suffered by reason of matters appearing of record in the office of the clerk and recorder subsequent to the date of issuance of a title insurance commitment and prior to the recording of closing documents for the real property concerned.

(3.9) "Net admitted assets" means the title insurance company's net admitted assets as reported pursuant to section 10-3-208.

(4) "Net retained liability" means the total liability retained by a title insurance company under any policy or contract of insurance, or under a single insurance risk as defined in or computed in accordance with subsection (7) of this section, after the purchase of reinsurance.

(5) "Premium" for title insurance is the amount charged by a title insurance company, agent for a title insurance company, or either of them to an insured or an applicant for insurance for the assumption by the title insurance company of the risk created by the issuance of the title insurance policy, including the cost of doing business and a reasonable profit, but excluding service charge, if any.

(6) "Service charge" is the amount charged by a title insurance company, agent for a title insurance company, or either of them to an insured or an applicant for insurance to cover the cost of procuring and examining evidence of title.

(6.5) (a) "Settlement producer" means a person who is in a position to refer business that is incident to or a part of a settlement service. "Settlement producer" includes, but is not limited to, a person who:

(I) Buys or sells an interest in real property;

(II) Lends or borrows moneys with an interest in real property as security;

(III) Acts as an agent, representative, attorney, or employee of a person who:

(A) Buys or sells an interest in real property; or

(B) Lends or borrows moneys with an interest in real estate as security;

(IV) Is an associate of a person described in this subsection (6.5).

(b) Nothing in this subsection (6.5) shall be construed to include a title insurance company or a title insurance agent.

(6.7) "Settlement service" means any service provided in connection with a real estate settlement. "Settlement services" include, but are not limited to, the following:

(a) Title searches;

(b) Title examinations;

(c) The provision of title certificates;

(d) Title insurance;

(e) Services rendered by an attorney;

(f) The preparation of title documents;

(g) Property surveys;

(h) The rendering of credit reports or appraisals;

(i) Pest and fungus inspections;

(j) Services rendered by a real estate broker;

(k) Services rendered by a real estate appraiser;

(l) Home inspection services;

(m) The origination of a loan;

(n) The taking of a loan application;

(o) Processing of a loan;

(p) Underwriting and funding of a loan;

(q) Escrow handling services;

(r) The handling of the processing; and

(s) Closing of settlement.

(7) "Single insurance risk" means the insured amount of any policy or contract of title insurance issued by a title insurance company unless two or more policies or contracts are simultaneously issued on different estates in identical real property, in which event, it means the sum of the insured amounts of all such policies or contracts. Any such policy or contract that insures a mortgage interest that is excepted in a fee or leasehold policy or contract, and which does not exceed the insured amount of such fee or leasehold policy or contract, shall be excluded in computing the amount of a single insurance risk.

(8) "Title insurance" means insuring, guaranteeing, or indemnifying owners of real property or others interested therein against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to said property.

(8.5) "Title insurance agency" means a corporation, partnership, foreign entity, or domestic entity as those terms are defined in section 7-90-102, or association or other legal entity that transacts the business of title insurance.

(9) "Title insurance agent" means a person authorized by a title insurance company to solicit insurance or to collect premiums or to issue or countersign policies in its behalf.

(10) "Title insurance company" means any domestic company organized under the provisions of this article for the purpose of insuring titles to real property; any title insurance company organized under the laws of another state or foreign nation and licensed to insure titles to real estate within this state; and any domestic, foreign, or alien company having the power and authorized to insure titles to real estate within this state on or before July 1, 1969, and which meets the requirements of this article.

(11) "Title insurance entity" means a title insurance agent, title insurance agency, or title insurance company.

Source: L. 69: p. 520, § 1. **C.R.S. 1963:** § 72-26-2. **L. 87:** (3) amended and (3.5) and (3.7) added, p. 446, § 1, effective April 30. **L. 2006:** (1) amended and (1.5), (2.5), (6.5), and (6.7) added, p. 264, § 1, effective July 1. **L. 2015:** (1.3), (3.6), and (3.9) added, (SB 15-210), ch. 292, p.1190, § 1, effective August 5. **L. 2018:** IP amended and (8.5) and (11) added, (SB 18-125), ch. 73, p. 640, § 1, effective March 29. **L. 2025:** (3.6) repealed, (SB 25-277), ch. 244, p. 1235, § 4, effective August 6.

Editor's note: (1) Subsection (1) was originally numbered as subsection (1.3) in Senate Bill 15-210 but has been renumbered on revision for ease of location.

(2) Subsection (8.5) was numbered as subsection (9.5) in Senate Bill 18-125 but has been renumbered on revision for ease of location.

10-11-103. Compliance with article required. On and after July 1, 1969, no company shall underwrite or issue a policy of title insurance or otherwise engage in the business of title insurance in this state unless authorized by the provisions of this article to transact such a business.

Source: L. 69: p. 521, § 1. **C.R.S. 1963:** § 72-26-3.

10-11-104. Corporate form required. Any domestic title insurance company formed after July 1, 1969, shall be organized as a stock corporation as provided in section 10-3-101.

Source: L. 69: p. 521, § 1. **C.R.S. 1963:** § 72-26-4.

10-11-105. Financial requirements prior to this article. (1) Every domestic title insurance company which on July 1, 1969, has the capital required by law and whose reserve fund required by law has been approved by the state bank commissioner shall have until July 1 in the tenth year after July 1, 1969, to comply with the financial requirements of this article, but the capital and reserve fund of each such title insurance company shall at no time be less than that required by law immediately prior to July 1, 1969.

(2) The reserve fund required by law immediately prior to July 1, 1969, for each domestic title insurance company engaged in the business of title insurance shall be supervised by the commissioner on and after July 1, 1969. As soon as practicable, the state bank commissioner shall furnish to the commissioner a list of all such title insurance companies and an inventory of securities and deposits approved by said bank commissioner for the reserve fund of each such company, and shall deliver to the commissioner all such securities and deposits then on deposit with the state bank commissioner and all safe deposit box keys, deposit receipts, certificates of deposit, and other evidences or means of control thereof to the commissioner. Every bank, savings and loan association, or other escrow or depository agent is authorized to accept the substitution of the commissioner for the state bank commissioner on any certificate of deposit or deposit receipt or any authority to enter a safe deposit box with reference to any reserve fund of a title insurance company. Every such bank, savings and loan association, or other escrow or depository agent and the state bank commissioner shall be held harmless from any liability as a result of such substitution and shall take such action as may be necessary or advisable to effect such substitution.

Source: L. 69: p. 521, § 1. **C.R.S. 1963:** § 72-26-5.

10-11-106. Determination of insurability required. (1) No policy or contract of title insurance shall be written unless and until the title insurance company has caused to be conducted a reasonable examination of the title and has caused to be made a determination of insurability of title in accordance with sound underwriting practices for title insurance companies. Evidence thereof shall be preserved and retained in the files of the title insurance company or its agent for a period of not less than seven years after the policy or contract of title insurance has been issued. In lieu of retaining the original copy, the title insurance company, or the agent of the title insurance company, may, in the regular course of business, establish a system whereby all or part of these writings are recorded, copied, or reproduced by any photographic, photostatic, microfilm, microcard, miniature photographic, or other process which accurately reproduces or forms a durable medium for reproducing the original. This section shall not apply to either a company assuming no primary liability in a contract of reinsurance or a company acting as a coinsurer if one of the other coinsuring companies has complied with this section.

(2) A title insurance company shall not be obligated to make a written disclosure to its prospective insureds prior to the issuance of a title insurance policy of the following documents if a reasonable examination of title referred to in subsection (1) of this section reveals a recorded document that:

(a) Is a spurious lien or spurious document as defined in section 38-35-201, C.R.S.;

(b) Is not, according to sound underwriting practices for title insurance companies, an impairment of record concerning the property to be insured; or

(c) Although it may purport to do so, does not encumber the property to be insured.

Source: L. 69: p. 522, § 1. **C.R.S. 1963:** § 72-26-6. **L. 97:** Entire section amended, p. 38, § 4, effective March 20. **L. 99:** (1) amended, p. 27, § 1, effective August 4.

10-11-107. Powers. (1) Every title insurance company has the following powers:

(a) To do the business defined in section 10-11-102 (3) and (8);

(b) To own, manage, and maintain sets of abstract books and to make, compile, and sell abstracts of title to real estate;

(c) To acquire by purchase or otherwise, and to hold, sell, mortgage, or otherwise dispose of, real estate and personal property, or any interest therein, either within or without the state of Colorado and to loan or borrow money upon such real estate or personal property.

Source: L. 69: p. 522, § 1. **C.R.S. 1963:** § 72-26-7. **L. 83:** (1)(b) amended, p. 512, § 1, effective May 16.

10-11-108. Prohibitions. (1) A title insurance company or title insurance agent shall not:

(a) Engage in the business of guaranteeing the payment of the principal or the interest of bonds, notes, or other obligations;

(b) Transact, underwrite, or issue any kind of insurance other than title insurance;

(c) Give or receive or attempt to give or receive remuneration in any form pursuant to any agreement or understanding, oral or otherwise, for the referral of title insurance business;

(d) Give or receive or attempt to give or receive any portion or percentage of any charge made or received in connection with the business of title insurance if such charge is not for services actually rendered. For purposes of this article, "services actually rendered" shall include but not be limited to a reasonable examination of a title, including instruments of record, and a determination of insurability of such title in accordance with sound underwriting practices; "services actually rendered" shall not include the mere referral of title insurance business.

(2) Nothing in this article, or in any other provision of law governing the insurance industry, shall be construed to prohibit:

(a) Compensation by a title insurance company of an attorney who is licensed to practice in Colorado for services actually rendered in connection with a real estate transaction, regardless of whether such attorney represents a client in such real estate transaction. Compensation of the attorney for services actually rendered shall not include the payment of an hourly fee paid by the client combined with a payment from the title insurance company for the same service; except that prior to issuing any title insurance commitment, such attorney shall disclose to any party represented by such attorney in the transaction for which the commitment shall be issued that such attorney may be compensated for the issuance of such title insurance commitment.

(b) Payment to any person of a bona fide salary or compensation for payment of goods and facilities actually furnished or for services actually rendered.

(3) Any party to a transaction which is subject to this section shall have a right of action for any actual loss or damage resulting from any violation of this section.

Source: L. 69: p. 522, § 1. **C.R.S. 1963:** § 72-26-8. **L. 92:** Entire section amended, p. 1748, § 1, effective April 24.

10-11-109. Unearned premium reserve. (1) In lieu of those reserves required for other insurance companies, every domestic title insurance company, and every foreign or alien title insurance company which under the state of domicile is not required to maintain a substantially equivalent unearned premium reserve, shall, in addition to other reserves, establish and maintain a reserve to be known as the "unearned premium reserve" for title insurance, which shall, at all times and for all purposes, constitute the unearned portions of premiums due or received and shall be charged as a reserve liability of such title insurance company in determining its financial condition.

(2) The unearned premium reserve shall be retained and held by such title insurance company for the protection of the policyholders' interest in policies which have not expired. Except upon liquidation, dissolution, or insolvency, assets equal to the amount of such reserve shall not be subject to distribution among depositors or other creditors or stockholders of such title insurance company until all claims of policyholders or holders of other title insurance contracts or agreements of such title insurance company have been paid in full and all liability on the policies or other title insurance contracts or agreements, whether contingent or actual, has been discharged or lawfully reinsured. Income from the investment of the amount of such reserve shall be the unrestricted property of the title insurance company.

Source: L. 69: p. 522, § 1. **C.R.S. 1963:** § 72-26-9.

10-11-110. Amount of unearned premium reserve - release. (1) The unearned premium reserve of every title insurance company required to maintain such reserves in this state shall consist of:

(a) The amount of the unearned premium reserve held as of July 1, 1969, pursuant to law; and

(b) The amount of all additions required to be made to such reserve by this section, less the withdrawals therefrom as permitted by this section.

(2) On and after July 1, 1969, every title insurance company shall add to its unearned premium reserve, in respect to each title insurance policy, leasehold policy, contract, or reinsurance agreement issued by it, a sum equal to one dollar for each such policy, contract, or agreement, plus fifteen cents for each one thousand dollars face amount of net retained liability on each such policy, contract, or reinsurance agreement, as defined in section 10-11-102 (4), or the amount reinsured by it, and shall separately record the aggregate amounts so set aside and reserved in respect to such policies, contracts, or agreements written in each calendar year.

(3) The amounts set aside as additions to the unearned premium reserve shall be deducted from income in determining net profits of any title insurance company.

(4) For the purposes of determining the amounts of the unearned premium reserve that may be withdrawn pursuant to subsection (5) of this section, all policies, contracts of title insurance, or reinsurance agreements of title insurance shall be considered as dated July 1 in the year of issue.

(5) On and before December 31, 2000, the aggregate of the amounts set aside in unearned premium reserve in any calendar year pursuant to subsection (2) of this section shall be released from said reserve and restored to income pursuant to the following formula: One-tenth of said aggregate sum on July 1 of each of the five years next succeeding the year of addition to the reserve and one-thirtieth of said aggregate sum on July 1 of each succeeding year thereafter until the entire sum has been so released and restored to income. On and after January 1, 2001, the aggregate of the amounts set aside in unearned premium reserve in any calendar year pursuant to subsection (2) of this section shall be released from said reserve and restored to income in accordance with the formula prescribed by nationally recognized insurance statutory accounting principles.

(6) (Deleted by amendment, L. 2001, p. 286, § 11, effective March 30, 2001.)

(7) If substantially the entire outstanding liability under all policies, contracts of title insurance, and reinsurance agreements of any such title insurance company shall be reinsured, the value of the consideration received by a reinsuring title insurance company authorized to transact the business of title insurance in this state shall constitute, in its entirety, unearned portions of original premiums and shall be added to its unearned premium reserve, and shall be deemed, for recovery purposes, to have been provided for liabilities assumed during the year of such reinsurance. The amount of such addition to the unearned premium reserve of such assuming title insurance company shall be not less than two-thirds of the amount of the unearned premium reserve required to be maintained by the ceding title insurance company at the time of such reinsurance.

Source: L. 69: p. 523, § 1. **C.R.S. 1963:** § 72-26-10. **L. 2001:** (5) and (6) amended, p. 286, § 11, effective March 30.

10-11-111. Reserve for unpaid losses and loss expense. (1) Each title insurance company, in addition to other reserves, shall at all times establish and maintain reserves against unpaid losses, and against loss expense, and shall calculate such reserves by making a careful estimate in each case of the loss and loss expense likely to be incurred by reason of every claim presented, pursuant to notice from or on behalf of the policyholder, of a title defect in or lien or adverse claim against the title insured that may result in a loss or cause expense to be incurred for the proper disposition of the claim. The sums of the items so estimated shall be the total amounts of the reserves against unpaid losses and loss expenses of such title insurance company.

(2) The amounts so estimated may be revised from time to time as circumstances warrant but shall be redetermined at least once each year.

(3) The amounts set aside in such reserves in any year shall be deducted in determining the net profits for such year of any title insurance company.

Source: L. 69: p. 524, § 1. **C.R.S. 1963:** § 72-26-11.

10-11-112. Net retained liability. The net retained liability of any title insurance company under any single insurance risk, as defined in section 10-11-102 (4) and (7), shall not exceed fifty percent of the net amount remaining after deducting from the sum of its capital, surplus, unearned premium reserve, and voluntary reserves the value, if any, assigned in such summation to its title plant, all as shown in its most recent report on file with the commissioner. The same limitation shall apply to any secondary risk assumed by means of reinsurance or to any policy of excess coinsurance; except that, whenever the primary retained liability of a ceding company equals or exceeds ten percent of the single insurance risk liability, the net retained or assumed liability limit of this section may be increased by an additional two hundred fifty thousand dollars, but in no event above one hundred percent of the net amount remaining after deducting from the sum of its capital and surplus the value, if any, assigned in such summation to its title plant, all as shown by its most recent report on file with the commissioner. Nothing in this section is intended to limit the amount of a single insurance risk, as defined in section 10-11-102 (7), that may be written by a title insurance company; but it shall cede to one or more other title reinsurers, on or before the effective date of such writing, such portion of the said risk as shall be sufficient to bring its net retained liability thereunder within the limits prescribed in this section; and each such cession of risk shall be within the limits of this section as applied to the sum of the capital, surplus, unearned premium reserve, and voluntary reserves, less the value, if any, assigned in such summation to the title plants of the reinsuring company, as shown by its most recent report on file with the supervisory agency in the state of its domicile.

Source: L. 69: p. 524, § 1. **C.R.S. 1963:** § 72-26-12.

10-11-113. Power to reinsure. Any title insurance company may cede reinsurance of all or any part of its liability under one or more of its policies, contracts, or reinsurance agreements of title insurance to any reinsurer which meets or exceeds the financial requirements of a title insurance company to do business in this state and is authorized to engage in the business of reinsurance of title insurance in this or any other state; but no larger amount of reinsurance shall be ceded to any reinsurer on a single policy or contract of title insurance, or on any single insurance risk, as defined in section 10-11-102 (7), than such reinsurer would be permitted to

retain if authorized to engage in the business of title insurance in this state. Any title insurance company may also reinsure policies of title insurance issued by other insurance companies on risks located in this state or elsewhere. Any domestic title insurance company or any foreign or alien title insurance company authorized to do business in this state shall pay to this state taxes required on all business taxable within this state and reinsured, as provided in this section, with any foreign or alien company not authorized to do business within this state. Issuance of contracts of reinsurance by a reinsurer not authorized to engage in the business of title insurance in this state but authorized to engage in the business of title insurance or in the business of reinsurance of title insurance in any of the United States, which contracts reinsure policies of title insurance issued by a title insurance company authorized to engage in the business of title insurance in this state on real property located in this state, shall not of itself constitute the doing of business in this state by such reinsurer.

Source: L. 69: p. 525, § 1. **C.R.S. 1963:** § 72-26-13.

10-11-114. Legal investments and admitted assets. (1) Title insurance companies shall comply with the investment requirements for other insurance companies under the laws of this state but, in addition, may invest in a title plant. Such title plant shall be considered an admitted asset as provided by nationally recognized insurance statutory accounting principles. The real estate in which the title plant is housed shall be considered an investment under section 10-3-218. Subject to the limitations of this section and with the approval of the commissioner, a title insurance company may enter into agreements with one or more other title insurance companies authorized to do business in this state whereby such companies shall participate in the ownership, management, and control of a title plant to serve the needs of all such companies, or such companies may hold stock of a corporation owning and operating a title plant for such purposes.

(2) A title insurance company shall include as an admitted asset accounts receivable relating to gross premiums, less agent retention, in the course of collection. Accounts receivable that are more than ninety days past due from the date of notification of the issuance of the policy shall not be included as an admitted asset.

Source: L. 69: p. 525, § 1. **C.R.S. 1963:** § 72-26-14. **L. 2001:** Entire section amended, p. 287, § 12, effective March 30.

Cross references: For the regulation of insurance company's investments, see §§ 10-3-213 to 10-3-237.

10-11-115. Prior investments. Any investment of a title insurance company lawfully acquired before July 1, 1969, and which but for this section would be considered ineligible as an investment on such date shall be disposed of within five years from such date. The commissioner, upon application and proof that forced sale of any such investment would be contrary to the best interests of the title insurance company and its policyholders, may extend the period for sale or disposal of such investment for a further reasonable time, in no event to exceed three years.

Source: L. 69: p. 525, § 1. **C.R.S. 1963:** § 72-26-15.

10-11-116. Title insurance agents licensed. (1) (a) Title insurance agents shall be licensed in the manner provided for insurance producers in part 4 of article 2 of this title, except as otherwise provided in this section.

(b) Full-time employees of a corporate contractual agent of a title insurance company authorized by such company or such contractual agent to issue or countersign binders or policies in behalf of such title insurance company shall be so licensed.

(c) A license shall be issued to an attorney-at-law licensed to practice in this state if a title insurance company notifies the commissioner in writing of the name and address of each such attorney it desires to appoint as its agent and upon payment of the fees required by sections 10-3-207 and 24-31-104.5, C.R.S.

(2) No individual, partnership, corporation, or other legal entity contractually authorized by a title insurance company as its agent to issue or countersign binders or policies on its behalf, other than an attorney otherwise qualified under subsection (1)(c) of this section, shall be licensed unless, in addition to all other requirements of this article and of articles 1 to 3 of this title, the agent possesses actual paid-in cash capital, or, if an individual, has a net worth, of at least ten thousand dollars.

(3) Title insurance agents possessing a title plant, as described in section 10-11-114, may satisfy the requirements of subsection (2) of this section by submitting to the commissioner of insurance, in a form acceptable to the commissioner, the written affidavit of a certified public accountant stating that the agent's actual investment in the title plant equals or exceeds the applicable amount set forth in subsection (2) of this section, or, alternatively, that the aggregate of the agent's paid-in cash capital or net worth, as applicable, and the agent's actual investment in the title plant equals or exceeds the applicable amount set forth in subsection (2) of this section.

(4) A licensed contractual agent of a title insurance company shall preserve and retain its closing and settlement services and escrow files for a period of not less than seven years after the closing, or completion, of said files. In lieu of retaining the original files, a licensed contractual agent of a title insurance company may, in its regular course of business, establish a system whereby the files are recorded, copied, or reproduced by any photographic, microfilm, or other process which accurately reproduces or forms a durable medium for reproduction of the original files. Upon cessation of business by a contractual agent of a title insurance company the files shall be deposited with the division of insurance or with a title insurance company or licensed contractual agent of a title insurance company authorized by the division of insurance.

Source: L. 69: p. 526, § 1. **C.R.S. 1963:** § 72-26-16. **L. 77:** (1)(a) amended, p. 502, § 4, effective January 1, 1978. **L. 91:** (2) to (4) added, p. 1217, § 1, effective July 1. **L. 93:** (1)(a) amended, p. 1390, § 7, effective January 1, 1995. **L. 99:** (4) amended, p. 27, § 2, effective August 4. **L. 2010:** (1)(c) amended, (HB 10-1385), ch. 204, p. 883, § 5, effective May 5. **L. 2012:** (1)(c) amended, (SB 12-110), ch. 158, p. 561, § 7, effective July 1.

10-11-117. Title insurance agents - certain names prohibited. On and after July 1, 1969, no agent for a title insurance company shall adopt a firm name containing the words "title insurance", "title guaranty", or "title guarantee", unless such words are followed by the words "agent" or "agency". The words "agent" or "agency" must be in the same size and type as the

words preceding them. This section shall not apply to any title insurance company acting as agent for another title insurance company.

Source: L. 69: p. 526, § 1. **C.R.S. 1963:** § 72-26-17.

10-11-118. Title insurance - rules. (1) Title insurance rates and fees shall be regulated in the manner provided in part 4 of article 4 of this title.

(2) Prior to the effective date of any new or amended rate or fee, every title insurance company and title insurance agent shall file with the commissioner the new or amended rate or fee, with justification for the new or amended rate or fee. Each filing shall set forth its effective date, which shall be no earlier than thirty days after its receipt by the commissioner. The commissioner may promulgate rules to implement this subsection (2).

(3) No title insurance company or title insurance agent shall use any rate or fee in the business of title insurance prior to its effective date, and no rate or fee increase or decrease shall apply to title policies or services that have been contracted for prior to such effective date. All rates or fees shall be readily available to the public in each office of the title insurance company or title insurance agent in the county to which said rates or fees apply.

Source: L. 69: p. 526, § 1. **C.R.S. 1963:** § 72-26-18. **L. 79:** (1) amended, p. 377, § 14, effective July 1. **L. 81:** (2) R&RE, p. 562, § 2, effective July 1. **L. 2000:** Entire section amended, p. 468, § 8, effective August 2. **L. 2001:** (2)(b) amended, p. 19, § 1, effective March 9. **L. 2009:** Entire section amended, (HB 09-1155), ch. 22, p. 107, § 1, effective August 5.

Cross references: For the legislative declaration contained in the 2000 act amending this section, see section 1 of chapter 135, Session Laws of Colorado 2000.

10-11-119. Laws applicable. In addition to the provisions of this article, the laws governing insurance companies, except as they are inconsistent with the provisions of this article, shall apply to the business of title insurance and to title insurance companies.

Source: L. 69: p. 526, § 1. **C.R.S. 1963:** § 72-26-19.

10-11-120. Corporate existence preserved. The repeal of article 12 of chapter 31, C.R.S. 1963, shall not affect the corporate existence of corporations organized under the provisions of said article 12 if such corporations are on July 1, 1969, engaged in the business of title insurance or title insurance agents in this state. Such corporations in all other respects shall be subject to the provisions of this article and shall file with the commissioner a copy of its articles of incorporation and all amendments thereto certified by the secretary of state.

Source: L. 69: p. 527, § 5. **C.R.S. 1963:** § 72-26-20.

10-11-121. Application of article - other laws applicable. The provisions of this article shall apply to all title insurance companies, title insurance rating organizations, title insurance agents, applicants for title insurance, policyholders, and persons and business entities deemed to be engaged in the business of title insurance. In addition to the provisions of this article, the laws

governing insurance companies, except as they are inconsistent with the provisions or purposes of this article, shall apply to such persons and entities.

Source: L. 69: p. 528, § 6. **C.R.S. 1963:** § 72-26-21. **L. 92:** Entire section amended, p. 1573, § 95, effective May 20.

10-11-122. Title commitments - rules. (1) Every title insurance agent or title insurance company shall provide, along with each commitment for an owner's policy of title insurance pertaining to a sale of residential real property as defined in section 39-1-102 (14.5), C.R.S., a statement disclosing the following information:

(a) That the subject real property may be located in a special taxing district;

(b) That a certificate of taxes due listing each taxing jurisdiction will be obtained from the county treasurer of the county in which the subject real property is located or that county treasurer's authorized agent unless the proposed insured provides written instructions to the contrary; and

(c) That information regarding special districts and the boundaries of such districts may be obtained from the board of county commissioners, the county clerk and recorder, or the county assessor.

(2) Failure of a title insurance agent or a title insurance company to provide the statement required by subsection (1) of this section shall subject such agent or company to the penalty provisions of section 10-3-111 but shall not affect or invalidate any provisions of the commitment for title insurance.

(3) (a) Before issuing any owner's policy of title insurance pertaining to a sale of residential real property, unless the proposed insured provides written instructions to the contrary, a title insurance agent or title insurance company shall obtain a certificate of taxes due from the county treasurer or the county treasurer's authorized agent.

(b) To address circumstances in which a certificate of taxes cannot be obtained from the county treasurer or the county treasurer's authorized agent during the period in which the county treasurer is certifying the tax rolls, the commissioner of insurance shall promulgate rules, in accordance with article 4 of title 24, C.R.S., that identify alternative documentation that may be used and relied upon during that period. If a title insurance agent or title insurance company uses alternative documentation during this period, the agent or company shall obtain a tax certificate when it becomes available from the county treasurer or the county treasurer's authorized agent.

(4) (a) If a title insurance agent or title insurance company is required to provide the statement required by subsection (1) of this section, the agent or company shall also provide a statement substantially as follows:

COLORADO NOTARIES MAY REMOTELY NOTARIZE REAL ESTATE DEEDS AND OTHER DOCUMENTS USING REAL-TIME AUDIO-VIDEO COMMUNICATION TECHNOLOGY. YOU MAY CHOOSE NOT TO USE REMOTE NOTARIZATION FOR ANY DOCUMENT.

(b) Failure of a person to provide the statement required by this subsection (4) does not subject the person to any liability under this article 11 or to the penalty provisions of section 10-3-111 and does not affect or invalidate any provisions of the commitment for title insurance.

Source: L. 91: Entire section added, p. 779, § 1, effective June 4. **L. 92:** (3) amended, p. 2167, § 5, effective June 2; IP(1), (1)(b), and (2) amended, p. 994, § 3, effective July 1. **L. 2013:** (3)(b) amended, (SB 13-119), ch. 192, p. 788, § 1, effective October 1; IP(1), (1)(b), and (3)(a) amended, (SB 13-119), ch. 192, p. 788, § 1, effective January 1, 2015. **L. 2020:** (4) added, (SB 20-096), ch. 130, p. 567, § 8, effective December 31.

Cross references: For the legislative declaration in SB 20-096, see section 1 of chapter 130, Session Laws of Colorado 2020.

10-11-123. Notification of severed mineral estates. (1) For purposes of this section:

(a) "Mineral estate" means a mineral interest in real property.

(b) "Severed" means that the surface owner does not own all or any part of the mineral estate.

(c) "Surface estate" means an interest in real property that does not include the full mineral estate as shown by recorded documents that impart constructive notice in the office of the clerk and recorder of the county in which the real property is situated.

(d) "Surface owner" means the owner of the surface estate and any purchaser with rights under a contract to purchase all or part of the surface estate.

(2) A title insurance agent or title insurance company shall provide, as part of each title commitment for the issuance of an owner's title insurance policy, the following written statement when it is determined that a mineral estate has been severed from the surface estate:

(a) That there is recorded evidence that a mineral estate has been severed, leased, or otherwise conveyed from the surface estate and that there is a substantial likelihood that a third party holds some or all interest in oil, gas, other minerals, or geothermal energy in the property; and

(b) That such mineral estate may include the right to enter and use the property without the surface owner's permission.

(3) In determining compliance with this section, a title insurance agent or title insurance company may rely on recorded documents that impart constructive notice in the office of the clerk and recorder of the county in which the real property is situated and shall not be liable for any errors or omissions in such records.

(4) A title insurance company or title insurance agent may rely on any document purporting to sever mineral interests to act as notice of such severance when such document is recorded in the office of the county clerk and recorder in the county in which the real property is situated.

(5) A title insurance agent or title insurance company shall be deemed to be in compliance with this section when it relies on any document purporting to sever mineral interests or to act as notice of such severance when such document is recorded in the office of the county clerk and recorder of the county in which the real property is situated. No title insurance agent or title insurance company shall be liable for obligations above, or for an amount in excess of, those stated in the owner's policy of title insurance issued pursuant to the commitment for failure to comply with the provision of subsection (2) of this section.

Source: L. 2001: Entire section added, p. 485, § 1, effective July 1.

10-11-124. Affiliated business arrangements - rules - investigative information shared with division of real estate. (1) (a) An affiliated business arrangement is permitted where the person referring business to the affiliated business arrangement receives payment only in the form of a return on an investment and where it does not violate the provisions of section 10-11-108 (1).

(b) A title insurance company or a title insurance agent making a referral as part of an affiliated business arrangement shall disclose the affiliation in accordance with the federal "Real Estate Settlement Procedures Act of 1974", as amended, 12 U.S.C. sec. 2601 et seq.

(c) Neither a title insurance company nor a title insurance agent shall require the use of an affiliated business arrangement or a particular settlement producer as a condition of obtaining title insurance services from the company or agent. For the purposes of this paragraph (c), "require the use" shall have the same meaning as "required use" in 12 CFR 1024.2.

(2) The commissioner may promulgate rules concerning the creation and conduct of an affiliated business arrangement, including, but not limited to, rules defining what constitutes a sham affiliated business arrangement. Nothing in this subsection (2) shall be construed to increase a fee or create a licensure program for affiliated business arrangements. The commissioner shall adopt the rules, policies, or guidelines issued by the United States department of housing and urban development concerning the federal "Real Estate Settlement Procedures Act of 1974", as amended, 12 U.S.C. sec. 2601 et seq. Rules adopted by the commissioner shall be at least as stringent as the federal rules and shall ensure that consumers are adequately informed about affiliated business arrangements. The commissioner shall consult with the real estate commission pursuant to section 12-10-218 (5) concerning rules the real estate commission may promulgate concerning affiliated business arrangements. Neither the rules promulgated by the commissioner nor the real estate commission may create a conflicting regulatory burden on an affiliated business arrangement.

(3) The division may share information gathered during an investigation of an affiliated business arrangement with the division of real estate.

Source: L. 2006: Entire section added, p. 266, § 2, effective July 1. **L. 2007:** (1)(b) and (2) amended, p. 2019, § 10, effective June 1. **L. 2019:** (2) amended, (HB 19-1172), ch. 136, p. 1652, § 38, effective October 1. **L. 2020:** (1)(c) amended, (HB 20-1402), ch. 216, p. 1043, § 15, effective June 30.

10-11-125. Fees, salaries, compensation, or other payments. (1) Nothing in section 10-11-124 or 10-11-126 shall be construed to prohibit payment of a fee to:

(a) An attorney for services actually rendered;

(b) A title insurance company to its duly appointed agent for services actually performed in the issuance of a policy of title insurance; or

(c) A lender to its duly appointed agent for services actually performed in the making of a loan.

(2) Nothing in section 10-11-124 or 10-11-126 shall be construed to prohibit payment to any person of:

(a) A bona fide salary or compensation or other payment for goods or facilities actually furnished or for services actually performed; or

(b) A fee pursuant to cooperative brokerage and referral arrangements or agreements between real estate brokers.

(3) It shall not be a violation of section 10-11-124:

(a) For an affiliated business arrangement to require a buyer, borrower, or seller to pay for the services of any attorney, credit reporting agency, or real estate appraiser chosen by the lender to represent the lender's interest in a real estate transaction; or

(b) For an affiliated business arrangement where an attorney or law firm represents a client in a real estate transaction and issues or arranges for the issuance of a policy of title insurance in the transaction directly as agent or through a separate corporate title insurance agency that may be established by that attorney or law firm and operated as an adjunct to his or her law practice.

Source: L. 2006: Entire section added, p. 267, § 2, effective July 1.

10-11-126. Affiliated business arrangements - enforcement - penalties. (1) The commissioner shall have the same remedies available to him or her as those available to the administrator of the department of housing and urban development in the federal "Real Estate Settlement Procedures Act of 1974", as amended, 12 U.S.C. sec. 2607.

(2) In addition to any other remedies available to the commissioner pursuant to this title, after notice and a hearing pursuant to section 24-4-105, C.R.S., the commissioner may assess a penalty for a violation of this article or a rule promulgated under this article. The penalty shall be the amount of remuneration improperly paid and shall be paid to the person aggrieved by the violation or apportioned among multiple aggrieved persons as determined by the commissioner.

(3) No person shall be liable for a violation of section 10-11-124 if such person proves by a preponderance of the evidence that such violation was not intentional and resulted from a bona fide error notwithstanding maintenance of procedures that are reasonably adopted to avoid such error.

Source: L. 2006: Entire section added, p. 268, § 2, effective July 1. **L. 2007:** (1) amended, p. 2020, § 11, effective June 1.

10-11-127. Fiduciary responsibilities of title insurance entities - definition of fiduciary funds - deceptive act or practice - rules. (1) A title insurance entity and its affiliates or subsidiaries in possession of fiduciary funds received and belonging to others shall hold those funds in a fiduciary capacity.

(2) The commissioner shall promulgate reasonable rules that are consistent with this section and are necessary or proper to:

(a) Require the segregation and accounting of fiduciary funds;

(b) Require notice to the commissioner by title insurance companies that are aware of a violation of the fiduciary fund segregation and accounting rules, and the appointment, suspension, or dismissal of title insurance agents; and

(c) Provide for the implementation and administration of this section.

(3) For the purposes of this section, "fiduciary funds" means any money received in conjunction with closing and settlement services other than a fee charged by the title insurance

company or title insurance agent to perform the closing and settlement services for a real estate transaction.

Source: L. 2018: Entire section added, (SB 18-125), ch. 73, p. 640, § 2, effective March 29.

PART 2

TITLE INSURANCE COMMISSION

10-11-201. Title insurance advisory group - meetings - response by commissioner - subject to review - repeal. (1) Twice each year, the commissioner shall hold a meeting of representatives of the title insurance industry, who are referred to in this section as the "title insurance advisory group" or "advisory group". The advisory group is an advisory body to the commissioner concerning the promotion of fair competition, consumer protection, and regulatory compliance in matters of title insurance. Nothing in this section divests the commissioner of the commissioner's authority to regulate the business of insurance.

(2) Meetings of the advisory group must be open to the public, and any member of the public may participate in a meeting.

(3) Members of the title insurance advisory group are not employees of the division and shall not receive compensation for service on the advisory group.

(4) The commissioner shall hold the first meeting of the title insurance advisory group on or before January 31 each year, and the commissioner shall hold the second meeting of the advisory group on or after June 1, but before August 1, each year unless an alternate time is proposed and accepted by the commissioner.

(5) The commissioner or the commissioner's designee shall attend each of the two regular meetings described in subsection (4) of this section. Advisory group members may conduct additional meetings as the commissioner deems appropriate.

(6) The commissioner shall respond in writing to formal written proposals or recommendations presented to the commissioner by the title insurance advisory group at a meeting.

(7) This section is repealed, effective September 1, 2029. Before the repeal, the advisory group is scheduled for review in accordance with section 2-3-1203.

Source: L. 2015: Entire part added, (SB 15-210), ch. 292, p. 1191, § 2, effective August 5. **L. 2022:** (2)(c)(I) amended, (SB 22-013), ch. 2, p. 7, § 6, effective February 25. **L. 2025:** Entire section amended, (SB 25-277), ch. 244, p. 1232, § 1, effective August 6.

10-11-202. Powers, duties, and functions - recommendations on rules. (Repealed)

Source: L. 2015: Entire part added, (SB 15-210), ch. 292, p. 1192, § 2, effective August 5. **L. 2025:** Entire section repealed, (SB 25-277), ch. 244, p. 1234, § 2, effective August 6.

10-11-203. Repeal of part. (Repealed)

Source: L. 2015: Entire part added, (SB 15-210), ch. 292, p. 1193, § 2, effective August 5. **L. 2025:** Entire section repealed, (SB 25-277), ch. 244, p. 1234, § 2, effective August 6.

MUTUAL INSURANCE

ARTICLE 12

Mutual Insurance

PART 1

MUTUAL INSURANCE COMPANIES AND
MUTUAL PROTECTIVE ASSOCIATIONS

10-12-101. Mutual protective associations. (1) One hundred or more persons, desiring to form and be members of a mutual protective association, are authorized to and may insure each other against loss or damage by any peril or perils resulting in physical loss or damage to property, including theft of personal property, situated in this state in which said persons have an insurable interest if said persons first subscribe their names and addresses to articles of association which provide and set forth:

(a) The name of said association, which shall contain the words "protective association";

(b) The city or town where the principal office of the association is located and where the books and records are maintained;

(c) The names and addresses of directors who shall serve for the first year of existence of the association, which number of directors shall not be less than three nor more than seven and which directors must be members;

(d) That members shall be entitled to one vote each and shall elect directors at each annual meeting for a term not to exceed three years, after the first year of existence. The members of said association shall consist of the one hundred or more persons subscribing the articles of association who shall also be policyholders bona fide applicants for insurance at the time their names are subscribed to the articles and, in addition, all other persons becoming policyholders thereafter for the period during the year in which their policies are in full force and effect. The policies of the members shall be effective concurrently with, or within one year from, the granting of a certificate of authority to said association. If the period of insurance coverage is less than a year, each member will be a full-fledged member for a complete year.

(e) The specific risks which said association purposes to insure, which shall be one or more of the risks specified in this section;

(f) The manner in which premiums will be charged or assessments levied against the members for the purpose of paying losses and expenses of management of said association; except that each association organized on or after April 20, 1949, and authorized to insure against any insurable risks specified in the articles of association and all said associations which charge an advance premium instead of operating on the pure assessment basis shall at all times maintain on deposit with the commissioner a sum equal to twenty-five thousand dollars in cash or convertible securities as a guaranty fund to guarantee faithful performance of the contract.

Upon dissolution, such guaranty fund shall become the property of the person who deposits it, subject to all claims provided for in sections 10-12-101 to 10-12-104.

(2) County mutual protective associations now operating in Colorado upon a pure assessment plan and such associations which do not write insurance upon growing crops but operate upon an assessment plan with the stated liability of each member set forth in its policies need not maintain any deposit with the commissioner nor maintain any reserves as provided in this section.

(3) Each association operating on an advance premium system and authorized to insure against any insurable risks specified in this section shall allocate and set aside at least sixty-five percent of all annual gross premiums received under all policies as a loss reserve to be used only for the payment of losses. In the event said loss reserve is insufficient to meet all adjusted loss claims for the year, an amount not exceeding five percent of the net premiums received shall be taken from the guaranty fund and added to the loss reserve to make up any deficit. The amount of said loss reserve then shall be distributed ratably among all policyholders suffering loss.

(4) Losses are defined as the actual amount paid the members and do not include any adjusting expenses or other expenses. If all losses are paid in full in any year and there is an excess sum remaining in the loss reserve, such excess sum shall be retained in the loss fund and shall be available for the following purposes in this order: Payment of current losses; recoupment by the company of all sums which have been removed from the guaranty fund in prior years to pay excess losses; as a permanent loss reserve fund.

Source: L. 49: p. 456, § 1. **CSA:** C. 87, § 91(1). **L. 51:** p. 468, § 1. **CRS 53:** § 72-5-1. **C.R.S. 1963:** § 72-5-1. **L. 92:** IP(1) amended, p. 1573, § 96, effective May 20.

10-12-102. Association to file articles - bylaws. After the articles of association have been subscribed and acknowledged in the manner provided for Colorado corporations, a certified copy thereof shall be filed with the commissioner, who shall obtain the approval of the attorney general and otherwise investigate to determine whether the association has complied with the provisions of sections 10-12-101 to 10-12-104. The association shall adopt bylaws and prepare applications and a list of policyholders, all of which, together with any amendments thereto, shall be filed with the commissioner. The commissioner shall issue a certificate of authority to an association which in his opinion has complied with the provisions of sections 10-12-101 to 10-12-104, and, if any provision has not been complied with, the commissioner shall suspend the certificate of authority until such time as compliance has been effected.

Source: L. 49: p. 458, § 2. **CSA:** C. 87, § 91(2). **CRS 53:** § 72-5-2. **C.R.S. 1963:** § 72-5-2.

10-12-103. Noncompliance a misdemeanor - penalty. (1) Upon failure of any association to comply with the provisions of sections 10-12-101 to 10-12-104, whether or not in possession of a valid certificate of authority, the officers and directors jointly and severally are guilty of a misdemeanor and, upon conviction thereof, each shall be punished by a fine of not less than five hundred dollars nor more than fifteen hundred dollars for each act in violation of sections 10-12-101 to 10-12-104.

(2) Any order or decision of the commissioner shall be subject to review, which shall be on the basis of the record of the proceedings before the commissioner and shall not be limited to questions of law, by appeal to the district court of the city and county of Denver at the instance of any party in interest.

(3) Such companies, organized and operating under existing laws, shall not be required to reorganize their corporate structure in order to be eligible to operate under sections 10-12-101 to 10-12-104.

Source: L. 49: p. 458, § 2. **CSA:** C. 87, § 91(2). **CRS 53:** § 72-5-3. **C.R.S. 1963:** § 72-5-3.

10-12-104. Fees - annual statement - tax. (1) The association shall pay to the division of insurance the fees as prescribed pursuant to section 10-3-207 (4).

(2) (a) Each agent, solicitor, special agent, or salaried representative soliciting business in this state shall be licensed by the division of insurance upon application of the association and shall be subject to the insurance licensing laws of the state. The fee for the initial license is five dollars, and the fee for filing each annual notice of intention to keep the agent's license in force is two dollars.

(b) Notwithstanding the amount specified for any fee in paragraph (a) of this subsection (2), the commissioner by rule or as otherwise provided by law may reduce the amount of one or more of the fees if necessary pursuant to section 24-75-402 (3), C.R.S., to reduce the uncommitted reserves of the fund to which all or any portion of one or more of the fees is credited. After the uncommitted reserves of the fund are sufficiently reduced, the commissioner by rule or as otherwise provided by law may increase the amount of one or more of the fees as provided in section 24-75-402 (4), C.R.S.

(3) The association shall render an annual statement of accounts and such records of the financial condition of the association as may be required by the commissioner, who shall furnish forms for this purpose. The commissioner shall have the same supervisory authority over such association as is provided by law in the case of other insurance companies and associations, and the commissioner shall collect two and one-fourth percent premium tax from each of the associations or companies as provided in section 10-3-209.

Source: L. 49: p. 459, § 3. **CSA:** C. 87, § 91(3). **CRS 53:** § 72-5-4. **C.R.S. 1963:** § 72-5-4. **L. 65:** p. 753, § 4. **L. 67:** p. 33, § 1. **L. 91:** (1) amended, p. 1233, § 7, effective June 5. **L. 98:** (2) amended, p. 1327, § 31, effective June 1.

10-12-105. Guaranty fund of mutual companies. (1) Guaranty fund certificates may be issued to provide a guaranty fund for domestic life and fire insurance companies incorporated upon the mutual plan and for domestic casualty insurance associations incorporated upon the assessment plan, such fund to be held as security for the payment of all losses and other policy liabilities of such companies. Guaranty fund certificates may draw interest or dividends not exceeding in the aggregate eight percent per annum, which shall only be paid from the profits of the company. The certificates may only be retired or redeemed by using the profits of the company for that purpose, but the full fund as required of each kind of mutual and assessment company by this title (except article 15), and article 14 of title 24, C.R.S., shall at all times be

maintained. Such guaranty fund shall be a liability until redeemed or retired. It shall only be used to pay policy claims or liabilities when the contingent mutual liability of the policyholders has been drawn upon and found insufficient to meet the losses of policy claims or when the directors for any cause fail to provide for the payment of policy claims.

(2) Upon satisfying himself of such failure, the commissioner shall suspend the certificate of authority of such company and apply to the district court for an order restraining said company from doing further business; and the court may appoint a receiver or issue such decrees and orders as may best serve the interests of the members or policyholders and of the public; and the disbursement or distribution of the guaranty fund shall then be made under the court's direction; but the fund shall first be used to pay policy claims or losses, and, if any of the fund then remains, it shall be used to pay creditors, if any, and the then remaining portion of the fund shall be used to redeem outstanding guaranty fund certificates, or, if none are outstanding, it shall be distributed among the members of the company as the court may direct. The profits of a domestic mutual insurance company or association are that portion of its cash funds not required for the payment of losses and expenses and not set apart for the unearned premium reserve or any other purpose required by law.

Source: L. 13: p. 361, § 63. **C.L.** § 2536. **CSA:** C. 87, § 80. **CRS 53:** § 72-5-5. **C.R.S. 1963:** § 72-5-5. **L. 92:** (1) amended, p. 1573, § 97, effective May 20. **L. 2004:** (1) amended, p. 903, § 23, effective May 21. **L. 2012:** (1) amended, (HB 12-1266), ch. 280, p. 1508, § 38, effective July 1.

10-12-106. Fees of mutual companies. Mutual and assessment companies, unless otherwise specified in this title (except article 15), and article 14 of title 24, C.R.S., are required to pay the same fees and be under the same supervision and authority of the commissioner as companies that are engaged in the same kind of insurance business and that are organized upon the joint-stock plan, and they shall comply with the general laws of this title, unless otherwise specified, and be subject to the penalties provided therein.

Source: L. 13: p. 364, § 65. **C.L.** § 2538. **CSA:** C. 87, § 82. **CRS 53:** § 72-5-6. **C.R.S. 1963:** § 72-5-6. **L. 92:** Entire section amended, p. 1573, § 98, effective May 20. **L. 2004:** Entire section amended, p. 903, § 24, effective May 21. **L. 2012:** Entire section amended, (HB 12-1266), ch. 280, p. 1508, § 39, effective July 1.

10-12-107. Ownership of profits. Every domestic insurance company incorporated upon the mutual or assessment plan shall state clearly in its policies or certificates that the accumulations of profits of such corporations over and above all proper liabilities are the sole property of the members or policyholders in good standing and that the same shall be distributed in a just and equitable manner in case such company is reinsured or ceases to do business.

Source: L. 13: p. 364, § 66. **C.L.** § 2539. **CSA:** C. 87, § 83. **CRS 53:** § 72-5-7. **C.R.S. 1963:** § 72-5-7.

10-12-108. Mutual insurance companies - corporation policyholders. Any public or private corporation, board, or association in this state or elsewhere may make applications and

enter into agreements for and hold policies in any domestic or foreign mutual insurance company. Any officer, stockholder, trustee, or legal representative of any such corporation, board, or association or any estate may be recognized as acting for or on its behalf for the purpose of such membership but shall not be personally liable upon such contract of insurance by reason of acting in such representative capacity. The right of any corporation organized under the laws of this state to participate as a member of any such mutual insurance company is declared to be incidental to the purpose for which such corporation is organized and as much granted as the rights and powers expressly conferred.

Source: L. 21: p. 465, § 8. **C.L.** § 2564. **CSA:** C. 87, § 134. **CRS 53:** § 72-5-8. **L. 55:** p. 457, § 1. **C.R.S. 1963:** § 72-5-8.

10-12-109. Mutual insurance companies - voting powers. Every member of the company shall be entitled to one vote or to a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as may be provided in the bylaws.

Source: L. 21: p. 465, § 9. **C.L.** § 2565. **CSA:** C. 87, § 135. **CRS 53:** § 72-5-9. **L. 55:** p. 457, § 1. **C.R.S. 1963:** § 72-5-9.

10-12-110. Mutual insurance companies - premiums and premium deposits. The policies shall provide for a premium or premium deposit payable in cash and, except as provided in this section, for a contingent premium at least equal to the premium or premium deposit. Such mutual company may issue a policy without a contingent premium while it has a surplus equal to the capital required of a domestic stock insurance company transacting the same kinds of insurance, and in no event shall the holder of any such policy be liable for a greater amount than the premium or premium deposit expressed in the policy. If at any time the admitted assets are less than the reserve and other liabilities, the company shall immediately collect upon policies with a contingent premium a sufficient proportionate part thereof to restore such assets, but no member shall be liable for any part of such contingent premium in excess of the amount demanded within one year after the termination of the policy. The commissioner may, by written order, direct that proceedings to restore such assets be deferred during the time fixed in such order.

Source: L. 21: p. 465, § 10. **C.L.** § 2566. **CSA:** C. 87, § 136. **CRS 53:** § 72-5-10. **L. 55:** p. 457, § 1. **C.R.S. 1963:** § 72-5-10.

10-12-111. Mutual life assessment companies prohibited - when. No life insurance company which is organized under the mutual assessment plan or which issues contracts, the performance of which is contingent upon the payment of assessments or calls made upon its members, shall do business in this state, except such companies authorized on April 15, 1913, to do business in this state and which value their assessment policies or certificates of membership as yearly renewable term policies, according to the standard of valuation of life insurance policies prescribed by the laws of this state. No such company shall provide in any contract of insurance for any cash or other benefit to accrue to any living member or policyholder or to any beneficiary except a death benefit from life insurance upon the yearly renewable term plan.

Source: L. 13: p. 358, § 60. **C.L.** § 2533. **CSA:** C. 87, § 77. **CRS 53:** § 72-5-11. **L. 55:** p. 458, § 1. **C.R.S. 1963:** § 72-5-11.

Cross references: For the valuation of life policies, see § 10-7-101.

10-12-112. Validation clause. All transactions, otherwise lawful and not inconsistent with sections 10-12-108 to 10-12-111, are hereby validated as though done pursuant to said sections.

Source: L. 55: p. 458, § 1. **CRS 53:** § 72-5-12. **C.R.S. 1963:** § 72-5-12.

PART 2

EMPLOYERS' MUTUAL LIABILITY INSURANCE

10-12-201 to 10-12-218. (Repealed)

Source: L. 2010: Entire part repealed, (HB 10-1220), ch. 197, p. 853, § 9, effective July 1.

Editor's note: This part 2 was numbered as article 8 of chapter 72, C.R.S. 1963. For amendments to this part 2 prior to its repeal in 2010, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

PART 3

MUTUAL BENEFIT ASSOCIATIONS

10-12-301 to 10-12-333. (Repealed)

Source: L. 81: Entire part repealed, p. 617, § 1, effective April 30.

Editor's note: This part 3 was numbered as article 9 of chapter 72, C.R.S. 1963. For amendments to this part 3 prior to its repeal in 1981, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

PART 4

MUTUAL INSURANCE COMPANIES

10-12-401. Legislative declaration. It is the intent of the general assembly by the enactment of this part 4 that the legal existence and status of mutual insurance companies formed under this part 4 and the members thereof be recognized beyond the limits of this state and that,

subject to any reasonable registration requirements, any such mutual insurance company transacting business outside this state be granted the protection of full faith and credit under section 1 of article IV of the constitution of the United States.

Source: L. 91: Entire part added, p. 1219, § 1, effective May 24.

10-12-402. Scope of provisions. This part 4 shall apply to all domestic and foreign mutual insurers, including captive insurance companies organized as mutual insurers, transacting or being organized to transact any of the kinds of business for which insurance companies regulated by this title are permitted.

Source: L. 91: Entire part added, p. 1219, § 1, effective May 24.

10-12-403. Mutual insurer defined. For purposes of this part 4, a "mutual" insurer is an insurance corporation without capital stock, owned by its policyholders collectively, who have the right to vote in the election of its directors.

Source: L. 91: Entire part added, p. 1219, § 1, effective May 24.

10-12-404. Company name. The corporate name of any company organized under this article shall contain the word "mutual" and shall not be the same as and shall be distinguishable on the records of the secretary of state from the name of any domestic company or of any foreign or alien company authorized to transact business in this state.

Source: L. 91: Entire part added, p. 1220, § 1, effective May 24. **L. 2000:** Entire section amended, p. 988, § 102, effective July 1.

10-12-405. Applicability of other code and corporation code provisions. Domestic mutual insurers, incorporating or qualifying to transact any or all of the classes of insurance designated in section 10-3-102, shall be subject to all provisions of this title generally applicable to other incorporated insurers, specifically including the provisions of article 3 of this title, and in case of conflict between this part 4 and other provisions of this title, the provisions of this part 4 shall control. Domestic mutual insurers shall be subject to additional articles of this title as they are applicable to the class or classes of insurance made by such domestic mutual insurer. Domestic mutual insurers shall not be required to have or issue capital stock or shares nor shall they be required to distribute an annual report to a member other than at the time of the initial policy issuance or once each year on renewal. Except as otherwise provided in this part 4, incorporated mutual insurers shall be deemed to be incorporated or organized under the general corporation law of this state.

Source: L. 91: Entire part added, p. 1220, § 1, effective May 24.

10-12-406. Lines of business. When permitted by its articles of incorporation, a company may be organized under this part 4 to make insurance to the same extent and for the

same purposes as permitted for domestic insurance companies under section 10-3-102 or for captive insurance companies under section 10-6-107.

Source: L. 91: Entire part added, p. 1220, § 1, effective May 24. **L. 94:** Entire section amended, p. 1648, § 88, effective May 31.

10-12-407. Bylaws. The bylaws shall provide that each policyholder of the company shall be a member of the company and shall be entitled to one or more votes based upon the amount of insurance in force, the number of policies held, or the amount of premium paid, as shall be stated in such bylaws. The bylaws may permit voting by proxy.

Source: L. 91: Entire part added, p. 1220, § 1, effective May 24.

10-12-408. Liability of members. (1) A member of a mutual insurance company organized under this article is not liable to any other member, to the company, or to any creditor of the company for the payment of losses or expenses of the company beyond payment of premiums for insurance issued to such member, nor may any member be assessed for any liability of the company.

(2) A mutual insurance company may, if permitted by its articles of incorporation or bylaws and if provision therefor is clearly disclosed to its members on the face of the policy, make contingent premium assessments on its members.

(3) No person is liable for any obligation arising from membership unless the person was admitted to membership upon the person's application or with the person's consent.

Source: L. 91: Entire part added, p. 1220, § 1, effective May 24.

10-12-409. Dividends. (1) The board of directors or trustees of any company which is subject to the provisions of this part 4 and which writes life, accident, or accident and health insurance may declare dividends to its members.

(2) After retaining sufficient funds for the payment by the company of all outstanding policy and other obligations, the board of directors or trustees of any company which is subject to the provisions of this article and which writes casualty, fidelity and surety, fire, elements and marine, or similar insurance may from time to time fix and determine the amount of dividends payable, or of unabsorbed or unused premiums or premium deposits to be returned, to each policyholder, may establish reasonable classifications or groupings of policyholders and plans for the distribution of such dividends or refunds upon each general kind of insurance or groups or classes thereof, and may establish reasonable territorial divisions upon policies expiring during a fixed period.

(3) The declaration and payment of dividends by any company subject to the provisions of this part 4 shall be subject to the following conditions:

(a) No dividends shall be declared or paid at any time except out of the earned, as distinguished from contributed, surplus nor when the surplus of the company is less than the original surplus required for the kind or kinds of insurance the company is authorized to write nor when the payment of such dividends will reduce its surplus to less than such amount.

(b) No dividends shall be declared or paid contrary to any restriction contained in the articles of incorporation.

Source: L. 91: Entire part added, p. 1221, § 1, effective May 24.

10-12-410. Insolvency or impairment of mutual insurance company. A mutual insurance company is deemed insolvent when its admitted assets are less than all of its liabilities, excluding from such liabilities the aggregate amount of its guaranty fund, and is deemed impaired when its admitted assets are less than its liabilities, including as a liability the aggregate amount of its guaranty fund, or when its surplus is less than the minimum requirements of section 10-3-201.

Source: L. 91: Entire part added, p. 1221, § 1, effective May 24.

10-12-411. Conversion of domestic mutual insurer to domestic stock or other form of insurer. (1) Any domestic mutual insurer may submit to the commissioner a petition and plan to convert, without reincorporation, into a domestic stock or other form of insurer pursuant to the requirements of this section.

(2) The petition and plan shall set forth with specificity the terms and conditions of the proposed conversion and shall do all of the following:

(a) Certify that the plan has been adopted by a majority vote of the board of directors of the insurer;

(b) Certify that the plan and the proposed conversion will not be prejudicial to the policyholders of the insurer;

(c) Specify the method and basis for the issuance of the capital stock of the converted stock or other form of insurer; and

(d) Provide copies of proposed amendments to the insurer's articles of incorporation and bylaws or other documents of organization to effectuate the conversion.

(3) The commissioner shall preliminarily approve the conversion after receiving the information provided in subsection (2) of this section.

(4) After receiving preliminary approval from the commissioner, the insurer shall do all of the following:

(a) Give notice, either personally or through mailing at least twenty-one days before the time fixed for the meeting, to the last-known postal address of each policyholder that the question of the conversion will be voted upon at a regular or special meeting of the policyholders. Such notice shall fairly but briefly describe the proposed conversion plan.

(b) Approve the conversion plan and any necessary amendments to the insurer's articles of incorporation and bylaws or other documents of organization, at the regular or a special meeting held in pursuance of the call and notice, by the affirmative vote of not less than two-thirds of the policyholders voting in person or by proxy; and

(c) Submit the conversion plan, together with proper proof that it has been approved by the policyholders as provided in this section, to the commissioner for final approval. The conversion plan shall not become effective until the commissioner issues an amended certificate of authority to the petitioner.

(5) Upon the issuance of the amended certificate of authority, the conversion shall be effective and the mutual insurer shall immediately become a stock or other form of insurer rather than a mutual insurer. The conversion into a stock or other form of insurer shall not affect any suits, rights, or contracts of the mutual insurer. In all other respects the rights and properties of the mutual insurer shall continue to be the property of the resulting stock or other form of insurer, which shall remain bound by all the obligations and liabilities of the mutual insurer. The stock or other form of insurer shall be deemed to have been organized at the time the converted mutual insurer was originally organized.

(6) Notwithstanding the requirements of paragraphs (a) and (b) of subsection (4) of this section, in the event of insolvency of the insurer, its board of directors by a majority vote may, in its petition, request that the commissioner waive the requirements of notice to and approval by the policyholders before submitting the petition and plan of conversion. Such petition shall specify both of the following:

(a) The method and basis for the issuance of the converted insurer's shares of its capital stock or other indication of ownership to an independent party in connection with an investment by such independent party in an amount sufficient to restore the insurer to a sound financial condition; and

(b) That the conversion shall be accomplished without distribution to the past, present, or future policyholders, if the commissioner finds that the value of the insurer, due to insolvency, is insufficient to warrant any such distribution.

(7) If the commissioner, upon review of the plan of conversion and the financial examination, finds that the domestic mutual insurer meets statutory requirements with respect to capital, surplus fund, and assets, the commissioner may, by a written order, waive the requirements of paragraphs (a) and (b) of subsection (4) of this section.

(8) A domestic mutual insurer may, by a majority vote of its directors and upon approval of the commissioner, abandon such plan for conversion at any time before the issuance of the final order of the commissioner. Upon such abandonment, all rights and obligations arising out of the plan shall terminate and the insurer shall continue to conduct its business as a domestic mutual insurer as though no such plan had ever been adopted.

Source: L. 91: Entire part added, p. 1222, § 1, effective May 24.

INTERINSURANCE

ARTICLE 13

Interinsurance

10-13-100.3. Definitions. As used in this article 13, unless the context otherwise requires:

(1) "Attorney" means an attorney, attorney-in-fact, agent, or other representative, as described in section 10-13-102.

(2) "Subscribers" means individuals, partnerships, and corporations of this state authorized to exchange reciprocal or interinsurance contracts, as described in section 10-13-101.

Source: L. 2025: Entire section added, (SB 25-275), ch. 377, p. 2037, § 41, effective August 6.

10-13-101. Interinsurance contracts. Subscribers are authorized to exchange reciprocal or interinsurance contracts with each other, or with individuals, partnerships, and corporations of other states and countries, providing indemnity among themselves from any loss which may be insured against under other provisions of the law, excepting life insurance, if such subscribers, through their attorneys, attorneys-in-fact, agents, or other representatives, deposit and maintain on deposit with the commissioner moneys or securities of the value of fifty thousand dollars as security for the performance of all such contracts issued in this state or in any other state or country by such subscribers and as security for any act or omission by an attorney-in-fact required to be bonded for or secured against under any attorney-in-fact bond required by the laws of any state in which the reciprocal or interinsurance exchange does business. Such securities shall be such as are required for lawful investments of capital and reserve of domestic insurance companies by the provisions of sections 10-3-215 to 10-3-230. In lieu of such deposit or part thereof, the commissioner may accept a certificate of the public official having supervision over insurers in any other state to the effect that a like deposit by such insurer or a like part thereof in an equal or a greater amount is held in public custody in such state. The offices through which such indemnity is exchanged shall be classified as reciprocal or interinsurance exchanges.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **L. 47:** p. 589, § 1. **CRS 53:** § 72-4-1. **C.R.S. 1963:** § 72-4-1. **L. 73:** p. 845, § 1. **L. 2025:** Entire section amended, (SB 25-275), ch. 377, p. 2037, § 42, effective August 6.

10-13-102. Licensing of solicitors. Contracts may be executed by an attorney duly authorized and acting for subscribers. Each attorney or exchange doing business in this state shall be required to license each solicitor, agent, special agent, special representative, or salaried representative soliciting business in this state. Such representative need not be a resident of this state, nor will such representative be required to countersign policies issued. The application for such license shall be made by the employer, and the commissioner shall issue to such individual requested in the application the required license upon payment of the usual agent's license fee if the individual is found by the commissioner to be qualified therefor.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **L. 47:** p. 590, § 2. **CRS 53:** § 72-4-2. **C.R.S. 1963:** § 72-4-2. **L. 2025:** Entire section amended, (SB 25-275), ch. 377, p. 2037, § 43, effective August 6.

Cross references: For fees for licensing agents, see § 10-3-207.

10-13-103. Declaration of subscribers. (1) Such subscribers so contracting among themselves shall through their attorney file with the commissioner of this state a declaration verified by the oath of such attorney setting forth:

(a) The name or title of the office at which such subscribers propose to exchange such indemnity contracts. Such name or title shall not be so similar to any other name or title

previously adopted by a similar organization or by any insurance corporation or association as in the opinion of the commissioner is calculated to result in confusion or deception.

(b) The kind of insurance to be effected or exchanged;

(c) A copy of the form of policy contract or agreement under or by which such insurance is to be effected or exchanged;

(d) A copy of the form of power of attorney or other authority of such attorney under which such insurance is to be effected or exchanged, which shall show the allowance for expense;

(e) The location of the office from which such contracts or agreements are to be issued;

(f) That applications have been made for indemnity upon at least one hundred separate risks aggregating not less than one and one-half million dollars, as represented by executed contracts or bona fide applications to become concurrently effective, or, in case of liability or compensation insurance, covering a total payroll of not less than one and one-half million dollars;

(g) A financial statement in such form as the commissioner may require;

(h) Such other information as the commissioner may deem necessary for the protection of the public.

Source: L. 13: p. 373, § 81. **L. 15:** p. 273, § 1. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-3. **C.R.S. 1963:** § 72-4-3.

10-13-104. Venue of actions - service of process. Concurrently with the filing of the declaration provided for by the terms of section 10-13-103, the attorney shall file with the commissioner an instrument in writing executed by him for said subscribers, conditioned that, upon the issuance of the certificate of authority provided for in section 10-13-111, action may be brought in the county in which the property insured thereunder is situated, and service of process may be had upon the commissioner or deputy commissioner in all suits in this state arising out of such policies, contracts, or agreements, which service shall be valid and binding upon all subscribers exchanging at any time reciprocal or interinsurance contracts through such attorney. Three copies of such process shall be served, and the commissioner shall file one copy, forward one copy to said attorney, and return one copy with his admission of service.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-4. **C.R.S. 1963:** § 72-4-4. **L. 73:** p. 847, § 2. **L. 86:** Entire section amended, p. 556, § 8, effective July 1. **L. 89:** Entire section amended, p. 438, § 10, effective July 1. **L. 92:** Entire section amended, p. 1574, § 99, effective July 1.

10-13-105. Maximum indemnity on single risk. There shall be filed with the commissioner by such attorney a statement under oath showing the maximum amount of indemnity upon any single risk, and such attorney, as often as the same is required, shall file with the commissioner a statement verified by his oath to the effect that he has examined the commercial rating of such subscribers as shown by the reference book of a commercial agency having at least one hundred thousand subscribers and that from such examination or from other information in his possession it appears that no subscriber has assumed on any single risk an amount greater than ten percent of the net worth of such subscriber.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-5. **C.R.S. 1963:** § 72-4-5.

10-13-106. Certificate of authority issued. (1) Upon the filing of the required papers, it is the duty of the commissioner to examine and pass upon the same and, if found in accordance with this title, to issue a certificate of authority which shall expire on April 1 next succeeding.

(2) To qualify for authority to transact insurance business in this state after July 1, 1971, every interinsurance exchange or reciprocal exchange shall possess and maintain an unencumbered surplus in an amount of not less than three hundred thousand dollars. Any interinsurance exchange or reciprocal exchange currently authorized to transact insurance business in this state need not meet such surplus requirements until five years after July 1, 1971; except that the surplus of any such interinsurance exchange or reciprocal exchange shall be increased annually at the rate of twenty percent of the difference between its surplus as of December 31, 1970, and three hundred thousand dollars. Upon written request and for good reason shown, the commissioner may waive the requirement for any one annual surplus increase, with the provision that said surplus increase will be accomplished in full within the next year, together with the surplus increase scheduled for that year.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-6. **C.R.S. 1963:** § 72-4-6. **L. 71:** p. 719, § 1. **L. 2001:** (1) amended, p. 1267, § 6, effective June 5.

10-13-107. Reserve required. There shall be maintained at all times an unearned premium reserve computed on a monthly or more frequent pro rata basis. The computation of this reserve shall be based upon premium deposits other than membership fees and without any deduction for expenses and the compensation of an attorney.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-7. **C.R.S. 1963:** § 72-4-7. **L. 71:** p. 720, § 2. **L. 75:** Entire section R&RE, p. 369, § 1, effective July 1.

10-13-108. Annual financial report. (1) Such attorney shall make a sworn annual report to the commissioner of the business of the preceding year ending December thirty-first, on or before the first day of March succeeding, showing that the financial condition of affairs at the office where such contracts are issued is in accordance with the standard of solvency, and shall furnish such additional information and reports as may be required to show the total premiums or deposits collected, the total losses paid, the total amounts returned to subscribers, and the amounts retained for expenses and subject to taxation. Such attorney shall not be required to furnish the names and addresses of any subscribers, except for purposes of verifying by the commissioner the reports furnished under section 10-13-105. These names and addresses are not to be filed or to become any part of the public records. The report shall be on a form prescribed by the commissioner.

(2) The business affairs and assets of any reciprocal or interinsurance exchange or attorney's office shall be subject to examination by the commissioner.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-8. **C.R.S. 1963:** § 72-4-8. **L. 64:** p. 144, § 74.

10-13-109. Authority conferred on corporations. Any corporation organized under the laws of this state, in addition to the rights, powers, and franchises specified in its articles of incorporation, has full power to exchange insurance contracts of the kind and character mentioned in section 10-13-101. The right to exchange such contracts is declared to be incidental to the purposes for which such corporations are organized and as much granted as the rights and powers expressly conferred.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-9. **C.R.S. 1963:** § 72-4-9.

Editor's note: The word "corporation" as used in this section is limited to those engaged in the business of insurance or suretyship. See definition in § 10-1-102 (6).

10-13-109.5. Exchange may hold and convey real estate. (1) Any reciprocal or interinsurance exchange authorized to transact business in this state may, in its own name, purchase, take, receive, lease, or otherwise acquire, own, hold, improve, use, and otherwise deal in and with real property, or have an interest in real property, wherever situated, and may sell, convey, assign, encumber, mortgage, pledge, lease, exchange, transfer, and otherwise dispose of all or any part of such real property or interest.

(2) (a) To encumber, transfer, or otherwise affect an estate or interest in real property in its own name, a reciprocal or interinsurance exchange shall execute and record, in the office of the clerk and recorder in the county in which such real property is located, a statement of authority that sets forth:

(I) The name of the reciprocal or interinsurance exchange;

(II) The address, including the street address, if any, of the reciprocal or interinsurance exchange; and

(III) The name of the person or entity authorized to encumber, transfer, or otherwise affect an estate or interest in real property in the name of the reciprocal or interinsurance exchange.

(b) The statement of authority shall be executed and acknowledged by the secretary or assistant secretary of the reciprocal or interinsurance exchange who is not the person authorized to encumber, transfer, or otherwise affect an estate or interest in real property in the name of the reciprocal or interinsurance exchange.

(c) An official with whom a statement of authority is recorded may charge and collect a fee for such recordation not to exceed the fee for recordation of an encumbrance or transfer of real property.

(d) After recording, a statement of authority, as it may be amended from time to time, shall remain effective until a cancellation thereof is recorded. An amendment or cancellation of a statement of authority shall meet the requirements for execution and recording of an original statement.

(e) The recorded statement of authority, any amendment thereof, and any cancellation thereof shall constitute prima facie evidence of the facts recited therein, the authority of the person executing such statement, amendment, or cancellation to execute and record such statement, amendment, or cancellation, and the authority of the person or entity named therein to

encumber, transfer, or otherwise affect an estate or interest in real property in the name of the reciprocal or interinsurance exchange.

(3) Any contract, deed, lease, mortgage, deed of trust, purchase or sale agreement, or any other contract, document, or instrument to be executed in the name of the reciprocal or interinsurance exchange may be executed by the person or entity designated in the recorded statement of authority of the reciprocal or interinsurance exchange.

(4) Notwithstanding the provisions of section 38-30-123, C.R.S., the power of attorney or other authorizing document actually executed by subscribers to the reciprocal or interinsurance exchange shall not be filed or recorded in or become part of the public records.

(5) The validity of transactions described in subsection (1) of this section entered into prior to July 1, 1996, and the rights, duties, and interests contained therein shall remain unimpaired and may be completed, confirmed, or enforced in accordance with the law or custom in effect prior to July 1, 1996, or pursuant to the terms of this section.

Source: L. 96: Entire section added, p. 145, § 1, effective April 8.

10-13-110. Noncompliance a misdemeanor. Any attorney, agent, or representative who, except for the purpose of applying for a certificate of authority, exchanges any contracts of indemnity of the kind and character specified in section 10-13-101 or directly or indirectly solicits or negotiates any application for the same without first complying with the provisions of this title is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than one hundred dollars nor more than one thousand dollars.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-10. **C.R.S. 1963:** § 72-4-10.

10-13-111. Annual certification - revocation. Each attorney by or through whom are issued any policies of or contracts for indemnity of the character referred to in this title shall procure from the commissioner annually a certificate of authority stating that all the requirements of this title have been complied with, and, upon such compliance and the payment of the fees and taxes required by this title, the commissioner shall issue such certificate of authority. The commissioner may revoke or suspend any certificate of authority issued in case of breach of any of the conditions imposed by this title after reasonable notice has been given said attorney in writing so that he may appear and show cause why such action should not be taken. Pending such investigation, no information shall be published, but, in case of revocation or suspension of a certificate of authority, notice of the same shall be published by the commissioner in the Denver daily newspapers. Any final action of the commissioner pursuant to this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-11. **C.R.S. 1963:** § 72-4-11. **L. 92:** Entire section amended, p. 1574, § 100, effective May 20.

10-13-112. Annual filing fee - tax. (Repealed)

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **L. 51:** p. 473, § 1. **CRS 53:** § 72-4-12. **C.R.S. 1963:** § 72-4-12. **L. 71:** p. 720, § 3. **L. 73:** p. 845, § 2. **L. 86:** Entire section amended, p. 556, § 9, effective July 1. **L. 89:** Entire section amended, p. 438, § 11, effective July 1. **L. 91:** Entire section amended, p. 1233, § 8, effective June 5. **L. 2000:** Entire section repealed, p. 1617, § 3, effective August 2.

10-13-113. Additional penalties. In addition to the foregoing penalties and where not otherwise provided, the penalty for failure or refusal to comply with any provisions or terms of this title, upon the part of the attorney, shall be the refusal, suspension, or revocation of the certificate of authority by the commissioner, and publication of his act, after due notice and opportunity for hearing as provided for in section 10-13-111.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-13. **C.R.S. 1963:** § 72-4-13.

10-13-114. Laws applicable. Except as they may be inconsistent with the provisions of this article, all other provisions of this title shall apply to interinsurance and reciprocal exchanges.

Source: L. 13: p. 373, § 81. **C.L.** § 2554. **CSA:** C. 87, § 98. **CRS 53:** § 72-4-14. **C.R.S. 1963:** § 72-4-14. **L. 71:** p. 720, § 4. **L. 73:** p. 846, § 3.

FRATERNAL BENEFIT SOCIETIES

ARTICLE 14

Fraternal Benefit Societies

Editor's note: This article was numbered as article 7 of chapter 72, C.R.S. 1963. The substantive provisions of this article were amended with relocations in 1993, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this article prior to 1993, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this article, see the comparative tables located in the back of the index.

PART 1

DEFINITIONS - STRUCTURE AND PURPOSE

10-14-101. Definitions. As used in this article, unless the context otherwise requires:

(1) "Benefit contract" means the agreement for the provision of benefits authorized by section 10-14-401, as that agreement is described in section 10-14-404.

(2) "Benefit member" means an adult member who is designated by the governing documents of the society to be a benefit member under a benefit contract.

(3) "Certificate" means the document issued as written evidence of the benefit contract.

(4) "Governing documents" mean the society's articles of incorporation, constitution, bylaws, and rules, however designated.

(5) "Lodge" means any subordinate member unit of the society, known as camps, courts, councils, branches, or by any other designation as described in section 10-14-103.

(6) "Premium" means any premium, rate, dues, or other required contributions by whatever name known, which are payable under the certificate.

(7) "Rule" means any rule, regulation, or resolution adopted by the supreme governing body or board of directors which is intended to have general application to the members of the society.

(8) "Society" means a fraternal benefit society as set forth in section 10-14-102, unless otherwise indicated.

Source: L. 93: Entire article amended with relocations, p. 585, § 1, effective July 1.

Editor's note: The former § 10-14-101 was relocated to § 10-14-102 in 1993.

10-14-102. Fraternal benefit societies - what constitutes. Any incorporated society, order, or supreme lodge, without capital stock, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides any of the benefits enumerated in section 10-14-401, is hereby declared to be a fraternal benefit society.

Source: L. 93: Entire article amended with relocations, p. 586, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-101 as it existed prior to 1993, and the former § 10-14-102 was relocated to § 10-14-103.

10-14-103. Lodge system - defined. (1) A society is operating on the lodge system if it has a supreme governing or legislative body and subordinate lodges into which members are elected, initiated, or admitted in accordance with its governing documents, and rituals. Subordinate lodges shall be required by the governing documents of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(2) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

Source: L. 93: Entire article amended with relocations, p. 586, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-102 as it existed prior to 1993, and the former § 10-14-103 was relocated to § 10-14-104.

10-14-104. Representative form of government - defined. (1) A society has a representative form of government when:

(a) The supreme governing body is either:

(I) An assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's governing documents. A society may provide for the election of delegates by mail. The elected delegates shall constitute at least a majority of the delegates and not less than two-thirds of the votes of the assembly and not less than the number of votes required to amend the society's governing documents. The assembly shall be elected, shall meet at least once every four years, and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's governing documents.

(II) A board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's governing documents. A society may provide for election of the board by mail. Each term of a board member shall not exceed four years. Vacancies on the board between elections shall be filled in the manner prescribed by the society's governing documents. Those persons elected to the board shall constitute at least a majority of the board and not less than the number of votes required to amend the society's governing documents. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least semiannually to conduct the business of the society.

(b) The officers of the society are elected either by the supreme governing body or by the board of directors, pursuant to the governing documents of the society;

(c) Only benefit members are eligible for election to the supreme governing body, the board of directors, or any intermediate assembly; and

(d) Each voting member has one vote. No vote may be cast by proxy.

Source: L. 93: Entire article amended with relocations, p. 586, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-103 as it existed prior to 1993, and the former § 10-14-104 was relocated to § 10-14-503.

10-14-105. Purposes and powers. (1) A society shall operate for the benefit of members and their beneficiaries by:

(a) Providing benefits as specified in section 10-14-401; and

(b) Operating for one or more lawful social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes for the benefit of its members, which may also be extended to others. Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(2) Every society shall have the power to adopt governing documents for the government of the society, the admission of its members, and the management of its affairs. Each society shall have the power to change, alter, add to, or amend such governing documents and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

Source: L. 93: Entire article amended with relocations, p. 588, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-113 (1)(b) and (6) as they existed prior to 1993, and the former § 10-14-105 was relocated to § 10-14-401.

PART 2

MEMBERSHIP

10-14-201. Qualifications for membership. (1) A society shall specify in its governing documents or rules:

(a) Eligibility standards for each and every class of membership. If benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than fifteen years of age and not greater than twenty-one years of age.

(b) The process for admission to membership for each membership class; and

(c) The rights and privileges of each membership class. Only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(2) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(3) Membership rights in the society are personal to the member and are not assignable.

Source: L. 93: Entire article amended with relocations, p. 588, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-108 as it existed prior to 1993.

10-14-202. Principal office - meetings - communications to members - grievance procedures. (1) The principal office of any domestic society shall be located in this state and comply with the provisions of section 10-3-128. The meetings of its supreme governing body may be held in any state, district, province, or territory wherein such society has at least one subordinate lodge, or in such other location as determined by the supreme governing body, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state.

(2) (a) A society may provide in its governing documents for an official publication in which any notice, report, or statement required by statute to be given to members, including notice of election, may be published. Such required reports, notices, and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(b) Not later than June 1 of each year, a synopsis of the society's annual statement, as of the immediately preceding December 31, providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

(c) A society may provide for procedures in its governing documents for grievances or complaints by members.

Source: L. 93: Entire article amended with relocations, p. 589, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-119 as it existed prior to 1993.

10-14-203. No personal liability. (1) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(2) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit, or proceeding, whether civil, criminal, administrative, or investigative, or threat thereof, in which the person may be involved by reason of the fact that such person is or was a director, officer, employee, or agent of the society or of any firm, corporation, or organization which such person served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed in relation to any matter in such action, suit, or proceeding as to which such person is finally adjudged to be or have been guilty of breach of a duty as a director, officer, employee, or agent of the society or in relation to any matter in such action, suit, or proceeding, or threat thereof, which has been made the subject of a compromise settlement, unless in either case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that such conduct was unlawful. The determination whether the conduct of such person met the standard required to justify indemnification and reimbursement in relation to any matter described in this subsection (2) may only be made by the supreme governing body or board of directors by a majority vote or a quorum consisting of persons who were not parties to such action, suit, or proceeding or by a court of competent jurisdiction. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required to justify indemnification and reimbursement. The right of indemnification and reimbursement pursuant to this subsection (2) shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of such person's heirs, executors, and administrators.

(3) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by such person in any such capacity or arising out of such person's status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

(4) No director, officer, employee, member, or volunteer of a society serving without compensation shall be liable, and no cause of action may be brought, for damages resulting from the exercise of judgment or discretion in connection with the duties or responsibilities of such person for the society unless such act or omission involved willful or wanton misconduct.

Source: L. 93: Entire article amended with relocations, p. 589, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-120 as it existed prior to 1993.

10-14-204. Waiver. The governing documents of the society may provide that no subordinate body nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the governing documents of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

Source: L. 93: Entire article amended with relocations, p. 590, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-121 as it existed prior to 1993.

PART 3

GOVERNANCE

10-14-301. Organization. (1) A domestic society organized on or after July 1, 1993, shall be formed as follows: Seven or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society may make, sign, and acknowledge before some officer competent to take acknowledgments of deeds, articles of incorporation. Such articles of incorporation shall contain:

(a) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(b) The purpose for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this article.

(c) The names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control and management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issue of the letter of authorization.

(2) The articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society, and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the commissioner, who may require such further information as the commissioner deems necessary. The bond with sureties approved by the commissioner shall be in such amount, not less than three hundred thousand dollars nor more than one million five hundred thousand dollars, as is required by the commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this article and all provisions of the statutes have been complied with, the commissioner shall furnish the incorporators a letter of authorization authorizing the society to solicit members as provided in this section.

(3) No letter of authorization granted under the provisions of this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the commissioner upon good cause shown, unless the five hundred applicants required in subsection (4) of this section have been secured and the organization has been completed as provided in this section. The articles of incorporation and all other proceedings pursuant thereto shall become null and void one year from the date of the letter of authorization, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as provided in this section.

(4) Upon receipt of a letter of authorization from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its tables of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for such advance premium, nor issue any certificate, nor pay, allow, offer, or promise to pay any benefit to any person until:

(a) At least ten subordinate lodges have been established into which the five hundred applicants have been admitted;

(b) There has been submitted to the commissioner, under oath of the president, secretary, or corresponding officer of such society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, and the amount of benefits to be granted and premiums therefor; and

(c) It is shown to the commissioner, by sworn statement of the treasurer or corresponding officer of such society, that at least five hundred applicants have each paid in cash at least one regular monthly premium as provided, which premiums in the aggregate shall amount to at least one hundred fifty thousand dollars. The advance premiums shall be held in trust during the period of organization, and, if the society has not qualified for a certificate of authority within one year, as specified in this section, the premiums shall be returned to said applicants.

(5) The commissioner may make such examination and require such further information as the commissioner deems advisable. The society shall submit articles of incorporation, which shall be issued in triplicate, to the commissioner and attorney general for examination. After being approved, the articles shall be filed and recorded in the office of the secretary of state who shall issue a certificate of incorporation. A copy of the articles, certified by the secretary of state, shall be filed with the commissioner. Upon presentation of satisfactory evidence that the society has complied with all the statutory provisions, including the establishment of a deposit with the commissioner of three hundred thousand dollars, unless the commissioner accepts a lesser amount, the commissioner shall issue to the society a certificate to that effect and that the society is authorized to transact business pursuant to the provisions of this article. The commissioner shall cause a record of the certificate of authority to be made. A certified copy of the record may be given in evidence with like effect as the original certificate of authority.

Source: L. 93: Entire article amended with relocations, p. 591, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-113 (1) to (5) as they existed prior to 1993.

Cross references: For persons before whom acknowledgments of deeds may be taken, see § 38-30-126.

10-14-302. Amendments to governing documents. (1) A domestic society may amend its governing documents in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its governing documents so provide, by referendum. Such referendum may be held in accordance with the provisions of its governing documents by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months after the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one of the methods specified in this section. Whenever a domestic society desires to amend its articles of incorporation, it shall file its certificate of amendment with the commissioner before filing the same with the secretary of state, and if the commissioner, with the advice of the attorney general, finds the same to be legally adopted and in due legal form and not in conflict with statutory provisions governing societies, then and not otherwise the certificate of amendment shall be filed with the secretary of state. Any other amendment of the governing documents of the society shall be filed with the commissioner. If the commissioner, with the advice of the attorney general, finds the amendment to be legally adopted and in due legal form and not in conflict with statutory provisions governing societies, then the amendment shall become operative upon filing, unless a later time is provided in the amendment or in the society's governing documents.

(2) Within ninety days after any amendment becomes operative, the amendment or amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that the same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof have been furnished to the addressee.

(3) Every foreign or alien society authorized to do business in this state shall file with the commissioner and the secretary of state a duly certified copy of all amendments of, or additions to, its articles of incorporation within ninety days after the enactment of the same in accordance with the provisions set forth in subsection (1) of this section. Any other amendment of the governing documents of the society shall be filed with the commissioner within ninety days after enactment.

(4) Printed copies of the governing documents, as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of the legal adoption thereof.

Source: L. 93: Entire article amended with relocations, p. 594, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-123 as it existed prior to 1993.

10-14-303. Institutions. A society may create, maintain, and operate, or may establish organizations to operate, not-for-profit institutions to further the purposes permitted by section 10-14-105 (1)(b). Such institutions may furnish services free or at a reasonable charge. Any real

or personal property owned, held, or leased by the society for this purpose shall be reported in every annual statement.

Source: L. 93: Entire article amended with relocations, p. 595, § 1, effective July 1.

10-14-304. Reinsurance. (1) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this state. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit is allowed as an admitted asset or as a deduction from liability to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after July 1, 1993, unless the reinsurance complies with the applicable provisions of part 7 of article 3 of this title and all pertinent insurance rules.

(2) Notwithstanding the limitation in subsection (1) of this section, a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under section 10-14-305.

Source: L. 93: Entire article amended with relocations, p. 595, § 1, effective July 1. **L. 2014:** (1) amended, (HB 14-1315), ch. 295, p. 1218, § 7, effective January 1, 2015.

10-14-305. Consolidations and mergers. (1) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the commissioner:

(a) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(b) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the commissioner but not earlier than the society's most recent financial report required pursuant to section 10-14-602;

(c) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's governing documents so permit, by mail;

(d) Evidence that at least sixty days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society; and

(e) Any other information deemed necessary by the commissioner.

(2) If the commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct, and that the consolidation or merger is just and equitable to the members of each, the commissioner shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the statutes of such state or territory and a certificate of such approval filed with the commissioner of this state or, if the statutes of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless

and until it has been approved by the commissioner or equivalent regulatory agency of such state or territory and a certificate of such approval filed with the commissioner of this state. In case such contract is not approved, it shall be inoperative, and the fact of its submission and its contents shall not be disclosed by the commissioner.

(3) Upon the consolidation or merger becoming effective as provided in this section, all the rights, franchises, interests, duties, and liabilities of the consolidated or merged societies in and to every species of property, real, personal, or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument; except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein vested under the laws of this state in any of the societies consolidated or merged shall not revert or be in any way impaired by reason of the consolidation or merger but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

(4) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document stating that such notice or document has been duly addressed and mailed shall be prima facie evidence that such notice or document has been furnished the addressees.

Source: L. 93: Entire article amended with relocations, p. 595, § 1, effective July 1. **L. 94:** (1)(b) amended, p. 1629, § 25, effective May 31.

Editor's note: This section is similar to former § 10-14-115 (1) as it existed prior to 1993.

10-14-306. Conversion of fraternal benefit society into a mutual or stock life insurance company. Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company or stock life insurance company by compliance with all the requirements of this title pertaining to a life insurance company. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No such conversion shall take effect unless and until approved by the commissioner, who may give such approval if the commissioner finds that the proposed change is in conformity with the statutory requirements and not prejudicial to the certificate holders of the society.

Source: L. 93: Entire article amended with relocations, p. 597, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-115 (2) as it existed prior to 1993.

PART 4

CONTRACTUAL BENEFITS

10-14-401. Benefits. (1) A society may provide the following contractual benefits as authorized by the certificate of authority issued:

(a) Death benefits;
(b) Endowment benefits;
(c) Annuity benefits;
(d) Temporary or permanent disability benefits;
(e) Hospital, medical, or nursing benefits;
(f) Monument or tombstone benefits to the memory of deceased members; and
(g) Such other benefits as authorized for life insurers and which are not inconsistent with this article.

(2) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (1) of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

Source: L. 93: Entire article amended with relocations, p. 597, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-105 as it existed prior to 1993.

10-14-402. Beneficiaries. (1) The owner of a benefit contract shall have the right at all times to change the beneficiary in accordance with the governing documents of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its governing documents, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(2) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member. The portion so paid shall not exceed the sum of one thousand dollars.

(3) If at the death of any person insured under a benefit contract there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid as provided in subsection (2) of this section, shall be payable to the estate of the deceased insured the same as other property not exempt; except that, if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

Source: L. 93: Entire article amended with relocations, p. 598, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-107 as it existed prior to 1993.

10-14-403. Benefits not attachable. No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by any society shall be liable to attachment, garnishment, or other process or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member, beneficiary, or any other person who may have a right thereunder either before or after payment by the society.

Source: L. 93: Entire article amended with relocations, p. 599, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-122 as it existed prior to 1993.

10-14-404. Benefit contract. (1) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided pursuant thereto. The certificate, together with any riders or endorsements attached thereto, the governing documents of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(2) Any changes, additions, or amendments to the governing documents of the society duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries and shall govern and control the benefit contract in all respects as though such changes, additions, or amendments had been made prior to and were in force at the time of the application for insurance; except that no change, addition, or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(3) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the governing documents of the society to the same extent as though the age of majority had been attained at the time of application.

(4) A society shall provide in its governing documents that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates or in lieu of or in combination therewith; however, the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(5) Copies of any of the documents specified in this section, certified by the secretary or corresponding officer of the society, shall be received as evidence of the terms and conditions thereof.

(6) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the commissioner in the manner provided for like policies issued by life insurers in this state. Every life, accident, health, or disability insurance certificate and every annuity certificate issued on or after July 1, 1994, shall meet the standard contract provision requirements not inconsistent with this article for like policies issued by life, sickness, and accident insurers in this state; except that a society may provide in its certificates for a grace period for payment of premiums of one full month. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's governing documents in force at the

time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the governing documents of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(7) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate, but no less than the legal age of majority. A society may require approval of an application for membership to effect this transfer and may provide in all other respects for the regulation, government, and control of such certificates and all rights, obligations, and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

(8) A society may specify the terms and conditions on which benefit contracts may be assigned.

Source: L. 93: Entire article amended with relocations, p. 599, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-109 as it existed prior to 1993.

10-14-405. Nonforfeiture benefits, cash surrender values, certificate loans, and other options. (1) For certificates issued prior to July 1, 1994, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall comply with the statutory provisions applicable immediately prior to July 1, 1993.

(2) For certificates issued on or after July 1, 1994, each certificate shall provide for paid-up nonforfeiture benefits, cash surrender values, loans, or other options in an amount and type not less than the corresponding amount ascertained in accordance with the statutes of this state applicable to life insurers issuing policies containing like benefits based upon applicable mortality tables.

Source: L. 93: Entire article amended with relocations, p. 601, § 1, effective July 1.

PART 5

FINANCIAL

10-14-501. Investments. A society shall invest its funds only in such investments as are authorized by the statutes of this state including but not limited to sections 10-3-210 to 10-3-242 and part 8 of article 3 of this title for the investment of the assets of life insurers.

Source: L. 93: Entire article amended with relocations, p. 601, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-111 as it existed prior to 1993.

10-14-502. Funds. (1) All assets shall be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(2) A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the governing documents of such society.

(3) A society may, pursuant to resolution of its supreme governing body and with prior written approval of the commissioner, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the statutory provisions and regulations regarding life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary to comply with any applicable federal or state statutes, or any rules issued pursuant thereto, the society may:

(a) Adopt special procedures for the conduct of the business and affairs of a separate account;

(b) Provide, for persons having beneficial interests therein, special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account; and

(c) Issue contracts on a variable basis to which section 10-14-404 (2) and (4) shall not apply.

Source: L. 93: Entire article amended with relocations, p. 602, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-110 as it existed prior to 1993.

Cross references: For the provisions regarding variable contracts issued by life insurers, see part 4 of article 7 of this title 10.

10-14-503. Exemptions. Except as provided in this section, societies shall be governed by the provisions of this article and shall be exempt from all other provisions of the insurance statutes of this state unless the terms of such statutes expressly apply to societies, or unless any such insurance statute is specifically made applicable to societies by this article. Societies shall comply with the applicable provisions of section 10-3-208; part 7 of article 3 of this title; and article 16 of this title.

Source: L. 93: Entire article amended with relocations, p. 603, § 1, effective July 1. **L. 2001:** Entire section amended, p. 1048, § 30, effective July 1. **L. 2013:** Entire section amended, (HB 13-1115), ch. 338, p. 1971, § 6, effective March 31, 2015. **L. 2016:** Entire section amended, (SB 16-189), ch. 210, p. 756, § 12, effective June 6.

Editor's note: This section is similar to former § 10-14-104 as it existed prior to 1993.

10-14-504. Taxation. Every society organized or licensed under this article is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from

all and every state, county, district, municipal, and school tax other than taxes on real estate and office equipment.

Source: L. 93: Entire article amended with relocations, p. 603, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-133 as it existed prior to 1993.

10-14-505. Rules and regulations of commissioner. The commissioner may establish and from time to time amend such reasonable rules and regulations as are necessary to enable the commissioner to carry out the commissioner's duties under the laws of this state and the provisions of this article.

Source: L. 93: Entire article amended with relocations, p. 603, § 1, effective July 1.

PART 6

REGULATION

10-14-601. Valuation. (1) Standards of valuation for certificates issued prior to July 1, 1994, shall be those provided by the statutes applicable immediately prior to July 1, 1993.

(2) The minimum standards of valuation for certificates issued on or after July 1, 1994, shall be based on the valuation methods, standards, and practices (including interest assumptions) set forth in the statutes of this state applicable to life insurers issuing policies containing like benefits.

Source: L. 93: Entire article amended with relocations, p. 603, § 1, effective July 1.

Cross references: For provisions regarding valuation of life insurance policies, see §§ 10-7-101, 10-7-309, and 10-7-309.5.

10-14-602. Reports. Reports shall be filed in accordance with the provisions of this section. Every society transacting business in this state shall annually, on or before the first day of March, file with the commissioner a true statement of its financial condition, transactions, and affairs for the preceding calendar year, unless for cause shown such time has been extended by the commissioner. The statement shall at least include the substance of that which is required by what is known as the convention blank form adopted from year to year by the national association of insurance commissioners for fraternal benefit societies, including any instructions, procedures, and guidelines not in conflict with the provisions of this article, actuarial statements and requirements of reserves in accordance with the statutes of this state applicable to life insurers, and any additional information required by the commissioner.

Source: L. 93: Entire article amended with relocations, p. 603, § 1, effective July 1.

10-14-603. Annual certificate of authority. Societies that are authorized to transact business in this state as of July 1, 1993, and all societies authorized thereafter, may continue

such business until June 30, 1994. The authority of all such societies may thereafter be renewed annually but shall terminate on the last day of the succeeding June. However, a certificate of authority so issued shall continue in full force and effect unless specifically terminated. For each such certificate of authority or renewal the society shall pay to the division of insurance fees as prescribed pursuant to sections 10-3-207 and 24-31-104.5, C.R.S. A duly certified copy or duplicate of such certificate of authority shall be prima facie evidence that the society is a fraternal benefit society within the meaning of this article.

Source: L. 93: Entire article amended with relocations, p. 604, § 1, effective July 1. **L. 2010:** Entire section amended, (HB 10-1385), ch. 204, p. 884, § 6, effective May 5. **L. 2012:** Entire section amended, (SB 12-110), ch. 158, p. 561, § 8, effective July 1.

Editor's note: This section is similar to former § 10-14-116 (1) as it existed prior to 1993.

10-14-604. Cash capital. To avoid situations where a society's transactions would create undue financial risks to its enrollees, subscribers, certificate holders, or the people of this state, the regulations specified in this section are authorized. The commissioner may by regulation establish standards consistent with those of the national association of insurance commissioners which require any society to maintain a minimum surplus level. The minimum surplus level shall reflect the type, volume, and nature of the insurance business being transacted and the type of entity for which the surplus levels are being established in accordance with the assessment features of societies. The regulation may additionally require the submission of an opinion by a qualified actuary which states whether the surplus level of the entity is sufficient for the authority requested.

Source: L. 93: Entire article amended with relocations, p. 604, § 1, effective July 1.

10-14-605. Examination of societies. The examination of societies, both at the initial formation and at any time during which any such society is authorized to transact business in this state, shall follow the same standards and procedures that apply to life insurers. The cost of any such examination may be assessed by the commissioner to be paid by the society.

Source: L. 93: Entire article amended with relocations, p. 604, § 1, effective July 1.

Cross references: For provisions relating to examination of insurance companies, see part 2 of article 1 of this title 10 and § 10-3-806.

10-14-606. Publications. Pending, during, or after an examination or investigation of any domestic, foreign, or alien society, the commissioner shall make public no financial statement, report, or finding, nor shall the commissioner permit to become public any financial statement, report, or finding affecting the status, standing, or rights of any such society, until a copy thereof has been served upon such society at its home office or until such society has been afforded a reasonable opportunity to answer any such financial statement, report, or finding and to make such showing in connection therewith as it may desire.

Source: L. 93: Entire article amended with relocations, p. 604, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-130 as it existed prior to 1993.

10-14-607. Grounds for injunction, liquidation, and receivership of domestic society. (1) The commissioner shall notify a domestic society when the commissioner upon investigation finds that a domestic society:

(a) Has exceeded its powers;

(b) Has failed to comply with any provision of this article;

(c) Is not fulfilling its contracts in good faith;

(d) Has a membership of less than four hundred after an existence of one year or more;

(e) Is conducting business fraudulently or in a manner hazardous to its members, creditors, or the public; or

(f) Is using methods which, although not otherwise specifically proscribed by statute, nevertheless renders its operation hazardous, or its condition unsound, to its members or the public.

(2) If the commissioner notifies a society pursuant to subsection (1) of this section, the commissioner may utilize the procedures, practices, standards, and provisions of parts 4 and 5 of article 3 of this title. In applying said provisions, the application of the assessment feature of the certificate shall be first considered.

Source: L. 93: Entire article amended with relocations, p. 605, § 1, effective July 1.

10-14-608. Foreign or alien society - admission. No foreign or alien society shall transact business in this state without a certificate of authority issued by the commissioner. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of this article applicable to domestic societies, excluding any deposit requirements in section 10-14-301 (5). Any such society may be authorized to transact business in this state upon filing with the commissioner such information as may be requested.

Source: L. 93: Entire article amended with relocations, p. 605, § 1, effective July 1.

10-14-609. Suspension - revocation - denial of license of foreign or alien society. (1) The commissioner shall notify a foreign or alien society of any of the deficiencies specified in this subsection (1) and state in writing the reasons for the commissioner's dissatisfaction when the commissioner, upon investigation, finds that a foreign or alien society transacting or applying to transact business in this state:

(a) Has exceeded its powers;

(b) Has failed to comply with any provision of this article;

(c) Is not fulfilling its contracts in good faith;

(d) Is conducting its business fraudulently or in a manner hazardous to its members, creditors, or the public; or

(e) Is using methods which, although not otherwise specifically proscribed by statute, nevertheless renders its operation hazardous, or its condition unsound, to its members or the public.

(2) As part of the notification required by subsection (1) of this section, the commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist be corrected. After such notice, the society shall have a thirty-day period in which to comply with the commissioner's request for correction, and, if the society fails to comply, the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its certificate of authority should not be suspended, revoked, or denied. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked, or denied, the commissioner may suspend or deny the certificate of authority of the society to do business in this state until satisfactory evidence is furnished to the commissioner that such suspension or denial should be withdrawn, or the commissioner may revoke the authority of the society to do business in this state.

(3) Nothing contained in this section shall be taken or construed as preventing any foreign or alien society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business in this state.

(4) In addition to the provisions of subsections (1) to (3) of this section, the provisions of section 10-1-110, except for the provisions of paragraphs (a) to (c) of subsection (1) of said section, shall apply to societies doing business in this state.

Source: L. 93: Entire article amended with relocations, p. 605, § 1, effective July 1. **L. 2003:** (4) amended, p. 618, § 18, effective July 1.

10-14-610. Injunction. No application or petition for injunction in proceedings for, the dissolution of, or the appointment of a receiver for any domestic, foreign, or alien society or lodge thereof shall be recognized in any court of this state unless made by the attorney general upon request of the commissioner.

Source: L. 93: Entire article amended with relocations, p. 606, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-128 as it existed prior to 1993.

10-14-611. Licensing of agents. Agents of societies shall be licensed in accordance with the statutory provisions regulating the licensing, revocation, suspension, or termination of a license of resident and nonresident agents as provided in part 4 of article 2 of this title, and subject to the exceptions provided in section 10-2-401 (3).

Source: L. 93: Entire article amended with relocations, p. 606, § 1, effective July 1; (2) amended, p. 1390, § 8, effective January 1, 1995. **L. 94:** Entire section amended, p. 741, § 2, effective January 1, 1995.

Editor's note: This section is similar to former § 10-14-116 (2) as it existed prior to 1993. Amendments made to § 10-14-116 (2) by House Bill 93-1270 were renumbered and harmonized with Senate Bill 93-072 and relocated to this section.

10-14-612. Unfair methods of competition and unfair and deceptive acts and practices. Every society authorized to do business in this state shall be subject to the provisions of part 11 of article 3 of this title relating to unfair insurance trade practices; except that nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

Source: L. 93: Entire article amended with relocations, p. 607, § 1, effective July 1.

PART 7

MISCELLANEOUS

10-14-701. Service of process. Societies authorized to do business in this state shall be subject to the same provisions and requirements regarding service of process as life insurers in accordance with section 10-3-107.

Source: L. 93: Entire article amended with relocations, p. 607, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-118 as it existed prior to 1993.

10-14-702. Fees. Except as otherwise specifically provided in this article, societies shall pay the applicable fees specified in sections 10-3-207 and 24-31-104.5, C.R.S., and be subject to the assessment of late fees pursuant to section 10-3-109 (3).

Source: L. 93: Entire article amended with relocations, p. 608, § 1, effective July 1. **L. 2010:** Entire section amended, (HB 10-1385), ch. 204, p. 884, § 7, effective May 5. **L. 2012:** Entire section amended, (SB 12-110), ch. 158, p. 562, § 9, effective July 1. **L. 2016:** Entire section amended, (SB 16-189), ch. 210, p. 756, § 13, effective June 6.

10-14-703. Review. All final decisions and findings of the commissioner made under the provisions of this article shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 93: Entire article amended with relocations, p. 608, § 1, effective July 1.

10-14-704. Penalties. (1) Any person, officer, member, or examining physician of any society authorized to do business under this article 14 who knowingly or willfully makes any false or fraudulent statement or representation in or with reference to any application for membership, or for the purpose of obtaining money from or benefit in any society transacting business under this article 14 commits a petty offense.

(2) Any person who willfully makes a false statement of any material fact or thing in a sworn statement as to the death or disability of a certificate holder in any such society for the purpose of procuring payment of a benefit named in the certificate of such holder and any person

who willfully makes any false statement in any verified report or declaration under oath required or authorized by this article is guilty of perjury in the second degree.

(3) Any person who solicits membership for, or in any manner assists in procuring membership in, any fraternal benefit society not licensed to do business in this state, or who solicits membership for, or in any manner assists in procuring membership in, any such society not authorized as provided in this article to do business in this state as defined in this article is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than one hundred dollars nor more than five hundred dollars.

(4) Any society, or any officer, agent, or employee thereof neglecting or refusing to comply with, or violating any of the provisions of this article, the penalty for which neglect, refusal, or violation is not specified in this section, is guilty of a misdemeanor, and upon conviction thereof, shall be punished by a fine of not more than two thousand dollars.

Source: L. 93: Entire article amended with relocations, p. 608, § 1, effective July 1. **L. 2021:** (1) amended, (SB 21-271), ch. 462, p. 3148, § 116, effective March 1, 2022.

Editor's note: This section is similar to former § 10-14-134 as it existed prior to 1993.

Cross references: For the provisions relating to perjury in the second degree, see § 18-8-503 and § 18-1.3-501; for the penalty for a petty offense, see § 18-1.3-503.

10-14-705. Exemption of certain societies. (1) Nothing in this article shall be construed to affect or apply to:

(a) Grand or subordinate lodges of masons, odd fellows, or knights of Pythias (exclusive of the insurance department of the supreme lodge knights of Pythias) or the junior order of united American mechanics (exclusive of the beneficiary degree or insurance branch of the national council junior order united American mechanics); nor to grand or subordinate lodges of societies, orders, or associations now doing business in this state which provide benefits exclusively through local or subordinate lodges; nor to similar societies which do not issue insurance certificates. Members of lodges of the independent order of odd fellows, knights of Pythias, and other organizations paying periodical or funeral benefits shall not be individually liable for the payment of periodical or funeral benefits or other liabilities of the lodge or other organizations, but the same shall be payable only out of the treasury of such lodges or organizations.

(b) Orders, societies, or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies, or associations.

(2) The commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether such society or association is exempt from the provisions of this article.

(3) Any fraternal benefit society organized and incorporated before June 2, 1911, and operating within the definition set forth in sections 10-14-101 to 10-14-104, providing for benefits in case of death or disability resulting solely from accidents, but which does not obligate itself to pay death or sick benefits, may be licensed under the provisions of this article and shall

have all the privileges and be subject to all the provisions and regulations of this article; except that the provisions of this article requiring medical examinations, valuations of benefit certificates, and that the certificate shall specify the amount of benefits shall not apply to such society.

Source: L. 93: Entire article amended with relocations, p. 608, § 1, effective July 1.

Editor's note: This section is similar to former § 10-14-132 as it existed prior to 1993.

PRENEED FUNERAL CONTRACTS

ARTICLE 15

Preneed Funeral Contracts

Editor's note: This article was numbered as article 19 of chapter 14, C.R.S. 1963. This article was repealed and reenacted in 1992 and was subsequently repealed and reenacted in 1995, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this article prior to 1995, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers prior to 1995 are shown in editor's notes following those sections that were relocated.

10-15-101. Legislative declaration. The general assembly declares that the business of selling preneed contracts whereby the seller agrees to provide final disposition or funeral merchandise or services in the future or for future use is affected with a public interest, and the preservation of the safety and welfare of the public from unconscionable dealing requires regulation of the sale of the contracts and of the disposition of funds obtained as a result of the sales.

Source: L. 95: Entire article R&RE, p. 1031, § 1, effective May 25. **L. 2021:** Entire section amended, (SB 21-006), ch. 123, p. 489, § 5, effective September 7.

Editor's note: This section is similar to former § 10-15-101 as it existed prior to 1995.

10-15-102. Definitions. As used in this article 15, unless the context otherwise requires:

(1) "Broker" means any contract seller who must utilize the services of a general provider to fulfill the terms of a preneed contract.

(1.5) "Cash advances" means consideration which can be used at the time of need at the discretion of the contract buyer or his or her heirs, assigns, or authorized representatives for merchandise or services the prices of which are not guaranteed in a preneed contract and which merchandise or services are ancillary and in addition to merchandise and services the prices of which are guaranteed in a preneed contract.

(2) "Cemetery" means any place, including a mausoleum, niche, or crypt, in which there is provided space either below or above the surface of the ground for the interment of the remains of human bodies.

(3) "Commissioner" means the commissioner of insurance.

(4) "Common trust funds" means a common trust as defined by the provisions of article 24 of title 11, C.R.S. This article does not preclude the use of a common trust to the extent that the individual contract seller complies with the provisions of this article.

(5) "Contract buyer" means a person who purchases merchandise and services through a preneed contract.

(6) "Contract seller" means a person who sells or offers to sell funeral goods, merchandise, or services through a preneed contract.

(7) "Final resting place" means a space, either below or above the surface of the ground, for the interment of the remains of human bodies.

(8) "Funds" means money paid by a contract buyer, excluding interest, finance charges, and late fees paid, for the purchase of a preneed contract.

(8.5) "Funeral goods" has the same meaning as in section 12-135-103 (17).

(9) "General provider" means a person who engages, on a contract basis, in the usual business of providing the merchandise and performing the services, at time of need, for the final disposition of a deceased human body, and does not include subcontractors of a general provider.

(10) "Merchandise" means goods which are normally sold or offered for sale directly to the public for use in connection with funeral services and does not include overhead items.

(11) "Overhead items" means items such as embalming fluid, sanitary supplies, and other items used in the performance of funeral services.

(12) "Person" means an individual, partnership, firm, joint venture, corporation, company, association, joint stock association, or limited liability company.

(13) (a) "Preneed contract" means any written contract, agreement, or mutual understanding, or any security or other instrument that is convertible into a contract, agreement, or mutual understanding, whereby, upon the death of the preneed contract beneficiary, a final resting place, merchandise, or services are provided or performed in connection with the final disposition of the beneficiary's body. Consideration for a preneed contract is funds, deposits, or the assignment of life insurance benefits.

(b) "Preneed contract" does not include:

(I) A contract for merchandise whereby the buyer takes physical possession of the merchandise at the time of entering into the contract; or

(II) A transportation protection agreement.

(c) (Deleted by amendment, L. 2013.)

(14) "Preneed contract beneficiary" means, for any preneed contract entered into on or after July 1, 1967, any person specified in the preneed contract, upon whose death a final resting place, merchandise, or services of any nature shall be provided, delivered, or performed.

(15) "Preneed contract price" means the total price listed on a preneed contract for all items listed and includes cash advances.

(16) "Services" means any services that may be used to care for and prepare deceased human bodies for final disposition.

(16.5) "Transportation protection agreement" means an agreement that primarily provides for the coordination and arrangement, by a third party that is not a general provider, of services related to:

(a) The preparation of human remains for the purpose of transportation; or

(b) The transportation of human remains.

(17) "Trustee" means a chartered state bank, savings and loan association, credit union, or trust company that is authorized to act as fiduciary and that is subject to supervision by the state bank or financial services commissioner or a national banking association, federal credit union, or federal savings and loan association authorized to act as fiduciary in Colorado.

(18) "Trust funds" means funds deposited by a contract seller with a trustee.

(19) "Trust instrument" means the documents pursuant to which a trustee receives, holds, invests, and disburses trust funds.

Source: L. 95: Entire article R&RE, p. 1031, § 1, effective May 25. **L. 2013:** (6) and (13) amended and (8.5) added, (SB 13-125), ch. 287, p. 1515, § 1, effective August 7. **L. 2019:** IP and (8.5) amended, (HB 19-1172), ch. 136, p. 1653, § 39, effective October 1. **L. 2021:** (16) amended, (SB 21-006), ch. 123, p. 489, § 6, effective September 7. **L. 2025:** (13)(b) amended and (16.5) added, (HB 25-1217), ch. 92, p. 414, § 1, effective August 6.

Editor's note: (1) This section is similar to former § 10-15-102 as it existed prior to 1995.

(2) Section 6(2) of chapter 92 (HB 25-1217), Session Laws of Colorado 2025, provides that the act changing this section applies to offenses committed on or after August 6, 2025.

10-15-103. License procedure - records - examination of records - definition - rules. (1) (a) A contract seller shall not enter into a preneed contract or accept any funds or other consideration without a license from the commissioner. To be valid, an application for an initial license must be in writing, signed by the applicant, and duly verified on forms furnished by the commissioner. Each application must be accompanied by payment of five hundred dollars and proof of either the net worth or surety bond requirements established by the commissioner by rule.

(b) (I) With the submission of the initial application described in paragraph (a) of this subsection (1), each applicant shall submit a set of fingerprints to the commissioner. The commissioner shall forward such fingerprints to the Colorado bureau of investigation for the purpose of conducting a state and national fingerprint-based criminal history record check utilizing records of the Colorado bureau of investigation and the federal bureau of investigation.

(I.5) When the results of a fingerprint-based criminal history record check of an applicant performed pursuant to this subsection (1)(b) reveal a record of arrest without a disposition, the commissioner shall require that applicant to submit to a name-based judicial record check, as defined in section 22-2-119.3 (6)(d).

(II) For purposes of this paragraph (b), "applicant" means an individual and, in the case of a corporation, each officer and director of the corporation.

(2) Upon receipt of a complete initial application and license fee, the commissioner shall issue a license to the applicant unless the commissioner determines that:

(a) The applicant has made false statements or misrepresentations in such application; or

(b) The applicant does not meet the conditions of subsection (1) of this section; or

(c) The applicant is not duly authorized to transact business in the state of Colorado; or

(d) Any officer, director, or controlling shareholder of the applicant has been convicted of a crime involving fraud or misappropriation or misuse of funds; or

(e) The applicant has not filed a preneed contract, general provider contract, or trust agreement and assignment form, where applicable, which comply with the provisions of this article; or

(f) The applicant is an insurance company.

(3) (a) The contract seller shall keep accurate accounts, books, and records of all transactions, copies of all preneed contracts, dates and amounts of payments made and accepted thereon, the name and address of each contract buyer, copies of all annual reports, the name of the preneed contract beneficiary as to each preneed contract, the name of the trustee holding trusted funds received under each preneed contract, copies of statutory reports made to the trustee and statutory reports provided by the trustee, and any other information necessary to verify compliance with the provisions of this article.

(b) Such records as stated in paragraph (a) of this subsection (3) shall be kept by the contract seller for at least five years following the earliest of the following:

(I) The death of the preneed contract beneficiary; or

(II) The removal of funds from trust; or

(III) The termination of the assignment of life insurance benefits.

(4) (a) The commissioner may investigate the books, records, and accounts of a contract seller to ensure that trust funds, preneed contracts, and preneed insurance policies comply with this article 15. The commissioner, or a qualified person designated by the commissioner, may examine the books, records, and accounts of the contract seller as often as necessary and may require the attendance of and examine under oath all persons whose testimony the commissioner needs for this purpose.

(b) The commissioner shall make every reasonable effort to utilize examiners employed by the division of insurance in preference to designating persons who are not employees of the division of insurance to perform examinations. If evidence of a violation of this article is known, the commissioner may designate a qualified person who is not an employee of the division of insurance to examine a contract seller, and the contract seller shall directly pay the reasonable expenses and charges of the examiner. The examinee may contest the amount of fees, costs, and expenses charged by the examiner by filing an objection with the commissioner that sets forth the charges the examinee considers to be unreasonable, together with the basis for disputing the charges. Amounts that are disputed are not due to the examiner until the commissioner has reviewed the objection and made a written finding that the disputed charges were reasonable for the examination performed.

(5) (a) Every license shall expire on June 30. Every license shall be renewed annually and automatically extended upon filing of a complete application on a form provided by the commissioner, demonstration of compliance with the conditions of subsection (2) of this section, payment of the fee prescribed in paragraph (b) of this subsection (5), and the filing of the annual report which shall be due by March 31 of each year. A filing made later than March 31 may be subject to a late fee of up to one hundred dollars per day for each day received after such date. If the contract seller is in compliance with this section, the contract seller shall be deemed licensed unless and until notified by the commissioner that the renewal does not comply with this section.

(b) The commissioner shall establish the annual renewal fee by rule based on the cost of regulating the industry and the outstanding preneed contract obligations of the contract sellers.

(6) Notwithstanding the amount specified for any fee in this section, the commissioner by rule or as otherwise provided by law may reduce the amount of one or more of the fees if necessary pursuant to section 24-75-402 (3), C.R.S., to reduce the uncommitted reserves of the fund to which all or any portion of one or more of the fees is credited. After the uncommitted reserves of the fund are sufficiently reduced, the commissioner by rule or as otherwise provided by law may increase the amount of one or more of the fees as provided in section 24-75-402 (4), C.R.S.

Source: L. 95: Entire article R&RE, p. 1034, § 1, effective May 25. **L. 98:** (6) added, p. 1328, § 32, effective June 1. **L. 2002:** (1) amended, p. 971, § 3, effective June 1. **L. 2010:** (4) amended, (HB 10-1220), ch. 197, p. 853, § 11, effective July 1. **L. 2013:** (1)(a) and (4) amended, (SB 13-125), ch. 287, p. 1516, § 2, effective August 7. **L. 2019:** (1)(b)(I.5) added, (HB 19-1166), ch. 125, p. 538, § 4, effective April 18. **L. 2022:** (1)(b)(I.5) amended, (HB 22-1270), ch. 114, p. 514, § 6, effective April 21; (1)(a), (4)(a), and (5)(b) amended, (HB 22-1228), ch. 309, p. 2223, § 3, effective August 10.

Editor's note: This section is similar to former § 10-15-103 as it existed prior to 1995.

10-15-103.5. Scope of article - exemptions. (1) This article does not apply to a person providing a developed final resting place within a designated cemetery approved for the interment, entombment, or inurnment of human remains.

(2) (a) A person providing an undeveloped final resting place is exempt from this article if the cemetery where the undeveloped final resting place is located contains unsold developed final resting places representing at least twenty-five percent of the outstanding paid-in-full contracts for undeveloped final resting places.

(b) If the specific and identifiable final resting place is not developed for use at the time of need and full payment has been made, then the contract must provide the purchaser with an immediate alternate and comparable final resting place at the same cemetery or with a full refund of moneys paid to qualify for the exemption under this subsection (2).

Source: L. 2013: Entire section added, (SB 13-125), ch. 287, p. 1517, § 3, effective August 7.

10-15-104. Annual report. Each contract seller shall file with the commissioner a report, on a calendar year basis, on a form provided by the commissioner. In the report, each contract seller that is required to deposit funds with a trustee shall state the name of each trustee where trust funds are on deposit and the amount remaining on deposit in the trust fund on December 31. Any contract seller that has voluntarily or involuntarily discontinued the sale of preneed contracts need not obtain a renewal of its license but shall continue to make annual reports to the commissioner until all the contracts have been fully performed.

Source: L. 95: Entire article R&RE, p. 1036, § 1, effective May 25. **L. 2013:** Entire section amended, (SB 13-125), ch. 287, p. 1517, § 4, effective August 7.

Editor's note: This section is similar to former § 10-15-104 as it existed prior to 1995.

Cross references: For state laws relating to investment of funds by savings and loan associations, see § 11-41-114; for investment of funds by banks, see § 11-105-304; for investment of funds by credit unions, see § 11-30-104.

10-15-105. Contract requirements - refund - full performance. (1) (a) The preneed contract shall bind the contract seller, or the heirs, assigns, or duly authorized representatives of the contract seller, to provide the services or merchandise contained in the preneed contract.

(b) (I) The contract seller shall certify pursuant to subparagraphs (II), (III), and (IV) of this paragraph (b) with the commissioner each form of preneed contract offered or sold by such contract seller unless the contract seller notifies the commissioner that it will use preauthorized forms made available by the commissioner. For preneed contracts that are funded by the assignment of life insurance benefits, the assignment shall be deemed to be part of the preneed contract, and the contract seller shall certify pursuant to subparagraphs (II), (III), and (IV) of this paragraph (b) with the commissioner a copy of each form of assignment.

(II) Each contract seller of preneed contracts shall submit an annual report to the commissioner listing any forms of preneed contracts and each form of assignment used or to be used by the contract seller. Such listing shall be submitted on or before July 15, 2000, and on or before July 1 of each subsequent year. The annual report shall include a certification by the contract seller that, to the best of the seller's knowledge, each form for preneed contracts and assignments in use complies with Colorado law. The commissioner may promulgate rules specifying the necessary elements of the certification.

(III) Each contract seller shall submit to the commissioner a list of new preneed contracts and forms of assignment. Such listing shall include a certification by the contract seller that, to the best of the seller's knowledge, each new preneed contract or form of assignment proposed complies with Colorado law. The commissioner may promulgate rules specifying the necessary elements of the certification.

(IV) The commissioner shall have the power to examine and investigate the preneed contract seller to determine whether the preneed contracts or forms of assignment comply with the seller's certification and Colorado law.

(c) At the time the preneed contract is entered into, the contract seller shall furnish the contract buyer with an accurate copy of the preneed contract.

(d) If the contract seller is a broker, or if the preneed contract requires any services to be performed or merchandise to be provided by a general provider other than the contract seller, the contract seller shall furnish the contract buyer with a copy of the agreement or a certificate evidencing an agreement between the contract seller and such general provider whereby the general provider or the heirs, assigns, or duly authorized representatives of such general provider are obligated to perform the services or provide the merchandise as stated in the preneed contract. Such agreement or certificate shall state that the general provider shall perform the contract services and provide the merchandise specified in the agreement between the contract seller and the general provider, under any fully paid preneed contract, without recourse against the contract buyer or his or her heirs, assigns, or duly authorized representatives for any funds due from the contract seller. Each such agreement or certificate evidencing each agreement shall be filed with the commissioner. As an alternative to having a separate agreement with a general

provider, the preneed contract shall contain a signature and statement of guarantee by the general provider or an authorized agent of said general provider to provide the merchandise and services as agreed in the preneed contract.

(2) A preneed contract shall be written in clear, understandable language and shall be printed or typed in at least eight-point type.

(3) A preneed contract shall conform to all other applicable state and federal statutes and regulations.

(4) Each preneed contract shall:

(a) State on its face that "This preneed contract is not insurance; however, preneed contracts and contract sellers are subject to regulation by the Colorado Division of Insurance."

(b) State the name and address of the principal office of the preneed contract seller and, if not the same, the name and address of the principal office of the general provider;

(c) Identify the contract buyer and the preneed contract beneficiary;

(d) State the terms and conditions for cancellation by the contract buyer within the first seven days of the contract buyer's signature to the preneed contract during which period the contract buyer may provide the contract seller with written notice of cancellation. The contract seller shall forward a one hundred percent refund to the contract buyer within ten calendar days of receipt of the written cancellation.

(e) Provide that the contract buyer may cancel the preneed contract at any time after the seven-day period provided in paragraph (d) of this subsection (4) and that any return of consideration be made to the contract buyer, heirs, assigns, or duly authorized representatives in a timely manner, not to exceed thirty days after the date of the request for return of consideration in lieu of performance, and not to exceed forty-five days after the date of request for return of consideration in case of default or cancellation;

(f) Contain a provision expressing the right of the contract seller to perform under the preneed contract if the heirs, assigns, or duly authorized representatives of the preneed contract beneficiary have not canceled the preneed contract within one hundred sixty-eight hours after the death of the preneed contract beneficiary, or if previously authorized to perform prior to such one hundred sixty-eight hours;

(g) Specify the services or merchandise, or both, to be provided, and clearly indicate that the preneed contract seller guarantees and fully pays for each such service or merchandise, or both, when it is provided, except for cash advances;

(h) Contain a provision providing that the preneed contract seller shall provide merchandise as described in the preneed contract or of equivalent quality;

(i) (I) State on its face the manner in which it is funded. Each preneed contract shall clearly state the terms of the consideration between the contract seller and the contract buyer.

(II) Such terms shall require that the contract buyer be responsible for paying any unpaid balance of the preneed contract price.

(III) Where the consideration is an assignment of life insurance benefits, excluding annuities, any unpaid balance shall not exceed the price of the services or merchandise provided at the time of death of the preneed contract beneficiary, based on the general provider's general price list then in force, in excess of the value of the assignment. Such assignment shall not require the payment of any unpaid balance after the third anniversary of the issue date of the preneed contract. The contract seller may require any assignment which has been reduced in value by action of the policy owner to be returned to full value.

(j) Contain a provision stating that the contract seller is responsible for furnishing the merchandise and services expressed in the preneed contract unless the contract buyer is in default, the contract is canceled, or the assignment funding the contract is void, canceled, or otherwise reduced in value by action of the contract buyer. The preneed contract shall provide that in the case of the death of the preneed contract beneficiary, the contract buyer or, if the contract buyer is deceased, such buyer's heirs, assigns, or duly authorized representatives are entitled to a full return of consideration instead of performance by the contract seller. It shall further provide whether or not a preneed contract, in case of default or cancellation, a preneed contract which has not been performed, or promissory note executed in connection therewith, may allow the contract seller to retain liquidated damages. In no event shall such liquidated damages exceed the lesser of the funds received or fifteen percent of the total preneed contract price. Such liquidated damages are deemed to be the reasonable value of administrative and sales costs incurred.

(5) Any preneed contract for which merchandise has been contracted, manufactured, and placed in storage shall guarantee that the merchandise, when delivered, shall be merchantable and fit for its intended purpose.

(6) No contract seller shall condition a preneed contract upon the purchase of any other item or contract unless such preneed contracts, other contracts, and any other item can be independently purchased at the same stated price. Nothing in this section shall prohibit the sale, purchase, or assignment of life insurance benefits to be identified in the preneed contract and be used as full or partial consideration to fund a preneed contract.

(7) The contract seller shall be deemed to have fully performed under the preneed contract when:

(a) The services or merchandise, or both, contracted for have actually been used in conjunction with the death of the preneed contract beneficiary; or

(b) The services contracted for have actually been furnished; or

(c) The contract buyer has taken physical possession of the merchandise; or

(d) The merchandise contracted for, which the contract buyer has agreed to purchase prior to need, has been manufactured and placed in storage and a certificate of title or warehouse receipt has been issued in the contract buyer's name, any such certificate of title or warehouse receipt having effectively and unalterably transferred ownership of the merchandise to the contract buyer and all such merchandise having been fully protected by casualty insurance against all hazards; or

(e) Full payment to the manufacturer has been made by the contract seller within forty-five days after the sale of the merchandise contracted for, which the contract buyer has agreed to purchase prior to need, by the contract buyer, the merchandise has been manufactured not later than six months thereafter and placed in storage, and a certificate of title or warehouse receipt has been issued in the contract buyer's name, any such certificate of title or warehouse receipt having effectively and unalterably transferred ownership of the merchandise to the contract buyer and all such merchandise having been fully protected by casualty insurance against all hazards, as stated in paragraph (d) of this subsection (7); or

(f) The merchandise contracted for, which the contract buyer has agreed to purchase prior to need, has been installed upon or placed within the interment site of the contract buyer, including the place of interment, entombment, or ground burial.

(8) In any preneed contract that includes merchandise contracted for pursuant to paragraphs (d) and (e) of subsection (7) of this section, upon full payment for the merchandise by the contract buyer, the title shall be deemed transferred to the contract buyer.

(9) (a) Notwithstanding any other provision of this section to the contrary, upon the request and consent of the contract buyer, a preneed contract, related trust, or assignment of the ownership or the benefits of a life insurance policy may be made irrevocable. However, the contract buyer, or the person with the right of final disposition may, at any time before performance, transfer the funds or the assignment to another contract seller or general provider as required by applicable laws.

(b) The contract buyer or, if the contract buyer has died, the person authorized to direct the disposition of the deceased contract buyer may select another funeral provider to provide the prearranged funeral merchandise and services. If another provider is selected, the original preneed seller may retain up to fifteen percent of the original preneed contract purchase price.

(10) (a) The contract seller shall:

(I) Disclose the name and address of the trustee who holds the preneed contract funds; and

(II) Notify the buyer when the preneed contract funds are deposited into trust.

(b) To comply with this subsection (10), the disclosure must advise the consumer to contact the commissioner if confirmation is not received by a specified time.

Source: L. 95: Entire article R&RE, p. 1036, § 1, effective May 25. **L. 2000:** (1)(b) amended, p. 469, § 9, effective August 2. **L. 2013:** (9) amended and (10) added, (SB 13-125), ch. 287, p. 1518, § 5, effective August 7.

Editor's note: This section is similar to former § 10-15-105 as it existed prior to 1995.

Cross references: For the legislative declaration contained in the 2000 act amending subsection (1)(b), see section 1 of chapter 135, Session Laws of Colorado 2000.

10-15-106. Preexisting contracts. This article shall not be construed so as to impair or affect the obligation of any preexisting lawful contract.

Source: L. 95: Entire article R&RE, p. 1041, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-106 as it existed prior to 1995.

10-15-107. Deposit of funds with trustee. (1) If a contract seller enters into a preneed contract in which the consideration is funds, the contract seller shall deposit not less than seventy-five percent of the total preneed contract price with a trustee. The contract seller shall deposit all funds in excess of twenty-five percent of the total preneed contract price with a trustee within forty-five days after receipt thereof. All funds deposited with a trustee shall be deposited under the terms of a trust instrument, which shall not be inconsistent or in conflict with the provisions of this article, and shall be held in trust by the trustee pursuant to the provisions of this article. Copies of all trust instruments and amendments to such trust instruments shall be filed with the commissioner.

(2) For each deposit with a trustee, the contract seller shall make a record of, and provide the trustee with, the name and address of the contract buyer, the total preneed contract price, and the amount of trustable funds. The contract seller shall keep such record, as to each contract buyer, until five years following the earlier of:

(a) The death of the preneed contract beneficiary; or

(b) The removal of funds from trust.

(3) Within thirty days following the last day of the calendar quarter, the contract seller shall provide to the trustee a detailed listing of all preneed contracts outstanding, the name and address of each contract buyer, the total preneed contract price, accumulated receipts, and the total amount of funds trusted for each preneed contract. If the trustee finds a significant discrepancy between such cumulative listing and the aggregate deposits in trust, the trustee shall contact the contract seller in order to reconcile the discrepancy. If the trustee is unable to resolve such discrepancy to the trustee's satisfaction, the trustee shall promptly notify the commissioner in writing of such discrepancy.

Source: L. 95: Entire article R&RE, p. 1041, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-107 as it existed prior to 1995.

10-15-108. Standard for investments by trustees. (1) Savings and loan associations acting as trustees under the terms of this article shall invest trust funds as otherwise authorized under the laws of this state relating to the investment of funds by savings and loan associations and the federal law governing such investments, but savings and loan associations shall accept trust funds only to the extent that the full amount thereof is insured by the federal deposit insurance corporation or its successor.

(2) Banks and trust companies acting as trustees under the terms of this article shall be subject to the following investment standards: In acquiring, investing, reinvesting, exchanging, retaining, selling, and managing property for the benefit of others, trustees shall be required to have in mind the responsibilities which are attached to such offices and the size, nature, and needs of the estates entrusted to their care and shall exercise the judgment and care under the circumstances then prevailing which men of prudence, discretion, and intelligence exercise in the management of their own affairs, not in regard to speculation but in regard to the permanent disposition of their funds, considering the probable income as well as the probable safety of their capital. Within the limitations of the standards set forth in this subsection (2), trustees are authorized to acquire and retain every kind of property, real, personal, and mixed, and every kind of investment, specifically including, but not by way of limitation, bonds, debentures, and other corporate obligations, savings accounts in insured savings and loan associations, stocks, preferred or common, securities of any open-end or closed-end management type investment company or investment trust, and participations in common trust funds, which men of prudence, discretion, and intelligence would acquire or retain for their own account.

(3) Credit unions acting as trustees under the terms of this article shall invest funds received under an account agreement as authorized under the laws of this state or the United States relating to the investment of funds by credit unions, but a credit union shall accept trust funds only to the extent that the full amount thereof is insured by the national credit union share insurance fund or other insurer approved by the commissioner of financial services.

Source: L. 95: Entire article R&RE, p. 1041, § 1, effective May 25. **L. 2004:** (1) amended, p. 148, § 52, effective July 1.

Editor's note: This section is similar to former § 10-15-108 as it existed prior to 1995.

10-15-109. Disbursements - excess trust assets. At reasonable times, and unless the trustee is notified by the commissioner that the preneed seller is in violation of the provisions of this article or by the contract seller not to disburse trust assets, the trustee shall disburse excess trust assets to the contract seller in accordance with the terms of the preneed contract between the contract buyer and the contract seller. The trustee shall not disburse any excess trust assets until such time as the value of such trust assets exceeds the total of all funds paid by the contract buyers under the preneed contracts. If more than one trust account is used by the contract seller, the aggregate of all trust accounts must exceed the total of all funds paid by all contract buyers before any disbursement by the trustee. It is the obligation and responsibility of the trustee to conduct at least annual valuations of the market value of the assets held in trust, which may include accrued interest.

Source: L. 95: Entire article R&RE, p. 1042, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-109 as it existed prior to 1995.

10-15-110. Discharge of preneed contract - disbursements by trustees. (1) Before disbursing any trust assets to discharge a preneed contract, the trustee shall determine that the amount of assets to be released does not exceed the funds trusted.

(2) If a preneed contract is canceled by the contract buyer or the contract buyer's heirs, assigns, or duly authorized representatives, the trustee shall require a copy of the signed cancellation request before releasing trust assets.

(3) If a preneed contract is canceled by the contract seller due to a default by the contract buyer, the trustee shall require an affidavit from an officer or owner of the contract seller setting forth such default before releasing funds.

(4) If a preneed contract is performed by the contract seller, the trustee shall require an affidavit from an officer or owner of the contract seller setting forth such performance before releasing funds.

Source: L. 95: Entire article R&RE, p. 1042, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-110 as it existed prior to 1995.

10-15-111. Insurance-funded preneed contracts. (1) If a contract seller enters into a preneed contract in which the consideration is the assignment of life insurance benefits, such preneed contract shall state that all or part of such assigned funds shall be paid to the contract seller to pay for the services or merchandise, or both, included in the preneed contract. The preneed contract and the assignment shall identify the policy being assigned including the name of the issuing company. The initial benefit assigned shall not exceed the preneed contract price

when the assignment is executed. The purchaser of any insurance policy to be assigned under a preneed contract must have an insurable interest in the life of the preneed contract beneficiary.

(2) If the value of the assignment exceeds the price of the preneed contract services or merchandise, or both, at the time of the death of the preneed contract beneficiary, based on the general provider's general price list in force in accordance with the regulations of the federal trade commission, the excess amounts shall be paid to the beneficiary under the policy or, if none, to the estate of the preneed contract beneficiary.

Source: L. 95: Entire article R&RE, p. 1043, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-111 as it existed prior to 1995.

10-15-111.5. Change of ownership - rules. (1) (a) A sale of an existing preneed contract that changes who provides funeral goods and services is void unless approved by the commissioner under this section. To transfer ownership, the contract seller must report a pending sale of the preneed contract to the commissioner in writing at least fourteen days before the sale closing. The notice must include:

(I) The name and address of the contract seller;

(II) The name and address of the organization proposing to acquire ownership of the preneed contract, referred to in this section as the "transferee";

(III) The name and address of the owners, operators, corporate officers, partners, or members of the transferee;

(IV) The name and address of the financial institution where preneed funds are held;

(V) The name under which preneed funds are held;

(VI) A description of each preneed contract, arrangement, or agreement included in the sale;

(VII) An accounting of the trust fund and all transferred and outstanding preneed contracts, including the number of pending contracts, the full contract value, the current value for each contract, a record of all disbursements from preneed trust accounts within the last twenty-four months, and the information required in the annual report;

(VIII) Any documents or amendments thereto concerning the trust or insurance funds, or any other preplanning or prefunding agreements;

(IX) A copy of the notice proposed to be sent to the contract buyers after the transfer; and

(X) Any other information that is reasonably required by the commissioner by rule.

(b) The commissioner may, by rule or order, waive or reduce any or all of the requirements in subparagraphs (I) to (X) of paragraph (a) of this subsection (1) as unnecessary or inappropriate in the public interest or for the protection of the contract buyers.

(2) (a) The commissioner shall approve the contract seller's application for change of ownership by written authorization if:

(I) The accounting is complete, accurate, and shows the trust fund is whole and intact;

(II) All required information and documents are filed with the commissioner; and

(III) The transferee holds a valid contract seller's license, or is qualified under section 10-15-103 for a contract seller's license, and is able to perform all transferred preneed contracts in accordance with this article.

(b) The commissioner shall approve or disapprove of the sale of an existing preneed contract in writing within sixty days after receiving the report required by paragraph (a) of subsection (1) of this section. If the commissioner fails to disapprove of the sale in writing within sixty days, the sale is deemed approved.

(3) (a) The contract seller, or person with an interest in the contract, remains liable for all funds and transactions until the effective date of the transfer.

(b) Any discrepancies, malfeasance, or fraud prior to the sale of the preneed contract is the responsibility of the seller, for which the seller is liable.

(4) Within thirty days after approval by the commissioner, the transferee of a preneed contract shall send a notice to the last-known address of each contract buyer informing the buyer of the change in ownership and the assumption of the obligation to perform the preneed contract.

Source: L. 2013: Entire section added, (SB 13-125), ch. 287, p. 1518, § 6, effective August 7.

10-15-111.7. Disposition of unclaimed preneed funeral contracts - unclaimed property trust fund. (1) Notwithstanding the failure of a preneed contract for funeral services beneficiary's heirs, assigns, or duly authorized representative to cancel a preneed contract for funeral services within one hundred sixty-eight hours after the death of the preneed contract beneficiary, each contract seller shall require a trustee with whom preneed contract funds have been deposited for a preneed contract that is unclaimed to report to the state treasurer as provided in section 38-13-401. The trustee shall comply with the requirements of the "Revised Uniform Unclaimed Property Act", article 13 of title 38, for deposit of the unclaimed preneed contract funds into the unclaimed property trust fund created in section 38-13-801 (1)(a).

(2) Except as otherwise specified in section 38-13-201 (1)(m) for a legacy preneed contract, as defined in section 38-13-102 (13.3), a preneed contract for funeral services is unclaimed at the earlier of the following:

(a) Three years after the date on which the contract seller has knowledge of the death of the preneed contract beneficiary, obtained through any source, including a declaration of death, a death certificate, a comparison of the contract seller's records against the United States social security administration's death master file, or other equivalent resource;

(b) The date the preneed contract beneficiary, if living, would have attained one hundred fifteen years of age; or

(c) Sixty-five years from the date that the preneed contract was executed.

(3) Except as otherwise specified in section 38-13-406 (1) for a legacy preneed contract, as defined in section 38-13-102 (13.3), for purposes of this section, the amount reportable for an unclaimed preneed contract is the amount paid by the contract buyer to the contract seller, less selling costs not to exceed fifteen percent of the total preneed contract price, liquidated damages, and contractual offsets, as authorized by law.

(4) Subsection (2)(a) of this section does not require a contract seller to compare the contract seller's records to the United States social security administration's death master file.

Source: L. 2022: Entire section added, (HB 22-1228), ch. 309, p. 2224, § 4, effective August 10. **L. 2025:** IP(2) and (3) amended, (HB 25-1224), ch. 440, p. 2531, § 1, effective June 4.

10-15-112. Rules. The commissioner may, after notice and hearing as provided in article 4 of title 24, C.R.S., promulgate such rules as may be reasonably necessary for the effective administration of and not inconsistent with the provisions of this article.

Source: L. 95: Entire article R&RE, p. 1043, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-112 as it existed prior to 1995.

10-15-113. Applicability of administrative procedure act. All procedures for the issuance, suspension, or revocation of licenses shall be pursuant to sections 24-4-104 to 24-4-107, C.R.S., except where inconsistent with the provisions of this article. Any final action with respect to the issuance, suspension, or revocation of licenses shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 95: Entire article R&RE, p. 1043, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-113 as it existed prior to 1995.

10-15-114. Investigations - actions against licensees. (1) The commissioner may impose an administrative fine not to exceed one thousand dollars for each separate offense; may issue a letter of admonition; may place a contract seller on probation under the commissioner's close supervision on such terms and for such time as the commissioner deems appropriate; and may refuse to renew, may revoke, or may suspend the license of any contract seller if, after an investigation and after notice and a hearing pursuant to the provision of section 24-4-104, C.R.S., the commissioner determines that the contract seller has:

(a) Failed to comply with or has violated any provision of this article or any regulation or order lawfully made pursuant to and within the authority of this article; or

(b) Used false or misleading advertising or made any false or misleading statement or concealment in the contract seller's application for licensure; or

(c) Employed any device, scheme, or artifice which results in defrauding a contract buyer; or

(d) Disposed of, concealed, diverted, converted, or otherwise failed to account for any funds or assets of any contract buyer which are subject to regulation pursuant to this article; or

(e) Committed any act that constitutes a violation of the "Colorado Consumer Protection Act", article 1 of title 6, C.R.S.; or

(f) Been convicted of, or any officer, director, or controlling shareholder has been convicted of, a crime involving fraud or misappropriation or misuse of funds; or

(g) Failed to provide appropriate records requested by the commissioner as part of an investigation of a complaint filed with the commissioner.

Source: L. 95: Entire article R&RE, p. 1043, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-114 as it existed prior to 1995.

10-15-115. Injunctions - cease-and-desist orders. (1) Whenever the commissioner has reasonable cause to believe that any person is violating any provision of this article or any rule or order promulgated pursuant to this article, the commissioner may:

(a) In the name of the people of the state of Colorado, through the attorney general, apply for an injunction in any court of competent jurisdiction to perpetually enjoin such person from committing any act prohibited by this article; or

(b) After notice and hearing pursuant to sections 24-4-104 and 24-4-105, C.R.S., issue an order to cease and desist the act or acts violating any provision of this article. A copy of the cease-and-desist order shall be furnished to each party.

Source: L. 95: Entire article R&RE, p. 1044, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-115 as it existed prior to 1995.

10-15-116. Surrender of license. (1) A contract seller may surrender a license by:

(a) Filing written notice with the commissioner;

(b) Submitting a list of all outstanding preneed contracts, including the name of the contract buyer, the method of funding for the preneed contract, the preneed contract price, the amount of funds received, and the amount of funds held in trust;

(c) Paying all outstanding fines and invoices due to the state of Colorado; and

(d) Submitting the current certificate of authority.

(2) Upon receipt of the notice, the commissioner shall review the preneed contract seller's trust funds and evidence of all outstanding preneed contracts.

(3) Upon determining that the available assets are sufficient to meet any remaining preneed contract liabilities, the commissioner shall deactivate the license.

(4) The contract seller shall continue to keep the trust fund intact and in trust after the license is inactive, and the trustee shall disburse the funds in trust in accordance with preneed contracts until the funds are exhausted.

(5) The commissioner has jurisdiction over the inactive contract seller and to require the reports required by section 10-15-104 and inspect the records required by this article so long as there are funds in trust or preneed contracts that are not fulfilled. When the funds in trust are exhausted or each preneed contract is fulfilled, the commissioner shall finally cancel the license of the contract seller.

(6) Upon a finding that an emergency exists that will harm consumers, the commissioner may by order administer preneed contracts and accounts if the business of the contract seller closes due to financial insolvency, criminal activity, or license suspension.

Source: L. 95: Entire article R&RE, p. 1044, § 1, effective May 25. **L. 2013:** Entire section amended, (SB 13-125), ch. 287, p. 1520, § 7, effective August 7.

Editor's note: This section is similar to former § 10-15-116 as it existed prior to 1995.

10-15-117. Reinstatement of license. The commissioner may reinstate a suspended license or issue a new license to a person whose license has been revoked if no fact or condition then exists which clearly would have justified the commissioner in refusing originally to issue

such license and the violations of this article which preceded the suspension or revocation of the license have been corrected.

Source: L. 95: Entire article R&RE, p. 1045, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-117 as it existed prior to 1995.

10-15-118. Violation. (1) Any person who violates any provision of this article 15 commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501. Any person who violates the trust fund provisions of this article 15 or any other misappropriation of funds commits theft pursuant to section 18-4-401.

(2) The commissioner may apply to a court of competent jurisdiction for the appointment of a receiver if the commissioner determines that such appointment is necessary to protect the interests of the contract buyers.

Source: L. 95: Entire article R&RE, p. 1045, § 1, effective May 25. **L. 2002:** (1) amended, p. 1468, § 28, effective October 1. **L. 2021:** (1) amended, (SB 21-271), ch. 462, p. 3149, § 117, effective March 1, 2022.

Editor's note: This section is similar to former § 10-15-118 as it existed prior to 1995.

Cross references: For the legislative declaration contained in the 2002 act amending subsection (1), see section 1 of chapter 318, Session Laws of Colorado 2002.

10-15-119. Immunity from prosecution. (1) If any person asks to be excused from attending and testifying or from producing any books, papers, records, correspondence, or other documents at any hearing on the ground that the testimony or evidence required of the person may tend to incriminate the person or subject the person to a penalty or forfeiture, and, notwithstanding such request, the commissioner directs such person to give such testimony or produce such evidence, such person shall nonetheless comply with such direction but the person shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which the person testifies or produces evidence pursuant thereto; and no testimony so given or evidence so produced shall be received against such person upon any criminal action, investigation, or proceeding. However, no person who has filed a waiver pursuant to subsection (3) of this section shall be immune from prosecution on account of testimony given or evidence produced.

(2) No person so testifying shall be exempt from prosecution or punishment for any perjury in the first degree committed by the person while so testifying, and the testimony or evidence so given or produced shall be admissible against the person upon any criminal action, investigation, or proceeding concerning such perjury; nor shall the person be exempt from the refusal, revocation, or suspension of any license, permission, or authority conferred, or to be conferred, pursuant to the laws of this state.

(3) Any person may execute, acknowledge, and file in the office of the commissioner a statement expressly waiving his or her immunity or privilege with respect to any transaction, matter, or thing specified in such statement, and thereupon the testimony of such person or such

evidence in relation to such transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, grand jury, or other authority, and if it is so received or produced, such individual shall not be entitled to any immunity or privilege on account of such testimony so given or evidence so produced. A waiver executed pursuant to this subsection (3) shall be valid only if it is:

(a) Entered into voluntarily;

(b) Executed by a person with the intellectual capacity to understand the consequences of executing such a waiver;

(c) Not executed under threat, coercion, or duress; and

(d) (I) Entered into knowingly.

(II) For purposes of this paragraph (d), a waiver is entered into knowingly when the person executing such waiver has been informed of his or her right to confer with independent legal counsel.

Source: L. 95: Entire article R&RE, p. 1045, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-119 as it existed prior to 1995.

Cross references: For perjury in the first degree, see § 18-8-502.

10-15-120. Rule against perpetuities inapplicable. No trust created pursuant to the provisions of this article, nor any interest therein, shall be deemed to be invalid by any existing law or rule against perpetuities or accumulations or suspension of the power of alienation and such trust and any interest therein may continue for such time as may be necessary to accomplish the purposes for which it may be created.

Source: L. 95: Entire article R&RE, p. 1046, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-120 as it existed prior to 1995.

10-15-121. Other insurance laws applicable. In addition to the provisions of this article, the provisions of article 1 of this title and parts 9 and 11 of article 3 of this title, except as they are inconsistent with the provisions or purposes of this article, shall apply to any person regulated pursuant to this article.

Source: L. 95: Entire article R&RE, p. 1046, § 1, effective May 25.

Editor's note: This section is similar to former § 10-15-121 as it existed prior to 1995.

10-15-122. Study of contract sellers - report - repeal. (Repealed)

Source: L. 2017: Entire section added, (SB 17-249), ch. 283, p. 1544, § 5, effective June 1.

Editor's note: Subsection (2) provided for the repeal of this section, effective September 1, 2018. (See L. 2017, p. 1544.)

10-15-123. Repeal of article. This article 15 is repealed, effective September 1, 2029. Before the repeal, the department of regulatory agencies shall review the regulation of preneed funeral contracts in accordance with section 24-34-104.

Source: L. 2017: Entire section added, (SB 17-249), ch. 283, p. 1544, § 6, effective June 1. **L. 2022:** Entire section amended, (HB 22-1228), ch. 309, p. 2222, § 2, effective August 10.

HEALTH-CARE COVERAGE

ARTICLE 16

Health-care Coverage

Editor's note: This article was numbered as article 24 of chapter 72, C.R.S. 1963. The substantive provisions of this article were repealed and reenacted in 1992, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this article prior to 1992, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this article, see the comparative tables located in the back of the index.

Cross references: For the "Uniform Unincorporated Nonprofit Association Act", see article 30 of title 7.

PART 1

GENERAL PROVISIONS

10-16-101. Short title. This article shall be known and may be cited as the "Colorado Health Care Coverage Act".

Source: L. 92: Entire article R&RE, p. 1617, § 1, effective July 1.

10-16-102. Definitions. As used in this article 16, unless the context otherwise requires:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of part 10 of this article, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person that directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Affiliation period" means a period of time, not to exceed two months, during which a health maintenance organization does not collect premiums and coverage issued is not yet effective.

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

(5) "Benefits ratio" means the ratio of the value of the actual benefits, not including dividends, to the value of the actual premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. "Benefits ratio" is also known as "targeted loss ratio".

(6) "Bona fide association" means, with respect to health insurance coverage offered in Colorado, an association that:

(a) Has been actively in existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association-sponsored insurance;

(c) Does not condition membership in the association on any health-status-related factor relating to an individual, including an employee of an employer or a dependent of an employee, and clearly so states in all membership and application materials;

(d) Makes health insurance coverage offered through the association available to all members regardless of any health-status-related factor relating to the members or individuals eligible for coverage through a member and clearly so states in all marketing and application materials;

(e) Does not make health insurance coverage offered through the association available other than in connection with a member of the association and clearly so states in all marketing and application materials; and

(f) Provides and annually updates information necessary for the commissioner to determine whether or not an association meets the definition of a bona fide association before qualifying as a bona fide association for the purposes of this article.

(7) "Bona fide volunteer":

(a) Has the meaning set forth in section 31-30-1202, C.R.S.;

(b) Means any volunteer member of a not-for-profit nongovernmental entity that is organized to provide firefighting services, emergency medical services, or ambulance services; and

(c) Means any volunteer member of a rescue unit as defined in section 25-3.5-103, C.R.S.

(8) "Carrier" means any entity that provides health coverage in this state, including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company,

and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and rules of Colorado.

(9) (a) "Case characteristics" means demographic characteristics that are considered by the carrier in the determination of premium rates for individuals and small employers.

(b) "Case characteristics" are limited to the following demographic characteristics, as further defined and determined by the commissioner by rule:

(I) The age of covered individuals;

(II) Geographic location of the policyholder;

(III) Family size; and

(IV) Tobacco use.

(10) "Catastrophic plan" means an individual health benefit plan that does not provide a bronze, silver, gold, or platinum level of coverage, as those coverage levels are described in section 10-16-103.4, and is available only to individuals under thirty years of age or who meet the eligibility requirements in federal law for participation in a catastrophic plan.

(11) "Child-only plan" means a health benefit plan issued on or after April 29, 2011, that provides coverage to an individual under twenty-one years of age. A "child-only plan" does not include coverage provided to a dependent under an individual or group health benefit plan.

(12) "Church plan" has the same meaning as set forth in 29 U.S.C. sec. 1002 (33) of the federal "Employee Retirement Income Security Act of 1974".

(13) "Commissioner" means the commissioner of insurance.

(14) "Control" has the same meaning as set forth in section 10-3-801 (3).

(15) "Covered person" means a person entitled to receive benefits or services under a health coverage plan.

(16) "Creditable coverage" means benefits or coverage provided under:

(a) Medicare, the "Colorado Medical Assistance Act", articles 4 to 6 of title 25.5, C.R.S., or the children's basic health plan established pursuant to article 8 of title 25.5, C.R.S.;

(b) An employee welfare benefit plan or group health insurance or health benefit plan;

(c) An individual health benefit plan;

(d) A state health benefits risk pool; or

(e) Chapter 55 of title 10 of the United States Code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States Code, a public health plan, or a health benefit plan under section 5 (e) of the federal "Peace Corps Act", 22 U.S.C. sec. 2504 (e).

(16.5) "Dementia diseases and related disabilities" is a condition where mental ability declines and is severe enough to interfere with an individual's ability to perform everyday tasks. Dementia diseases and related disabilities includes Alzheimer's disease, mixed dementia, Lewy body dementia, vascular dementia, frontotemporal dementia, and other types of dementia.

(17) "Dependent" means a spouse, a partner in a civil union, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent. "Dependent" includes a designated beneficiary, as defined in section 15-22-103 (1), C.R.S., if an employer elects to cover a designated beneficiary as a dependent.

(17.5) "EISA" means the federal "Employee Retirement Income Security Act of 1974", 29 U.S.C. sec. 1001 et seq.

(18) (a) "Eligible employee" means a full-time employee in a bona fide employer-employee relationship with an employer that has not been established for the purpose of obtaining a small group plan. The term does not include:

(I) An employee who works on a temporary or substitute basis;

(II) An individual and his or her spouse or partner in a civil union with respect to a trade or business, whether incorporated or unincorporated, that is wholly owned by the individual or by the individual and his or her spouse or partner in a civil union; or

(III) A partner in a partnership and his or her spouse or partner in a civil union with respect to the partnership; except that a partner and his or her spouse or partner in a civil union may participate in a small group plan established to cover one or more eligible employees of the partnership who are not partners in the partnership.

(b) Notwithstanding any provision of law to the contrary, an eligible employee of a small employer who could also be considered a dependent of the small employer must receive taxable income from the small employer in an amount equivalent to minimum wage for working full-time on a permanent basis in order to be considered an employee of the small employer.

(c) Nothing in this subsection (18) limits the employer's traditional ability to set valid and acceptable standards for employee eligibility based on the terms and conditions of employment, including a minimum weekly work requirement in excess of thirty hours and eligibility based upon salaried versus hourly workers and management versus nonmanagement employees.

(19) "Emergency service provider" means a local government, or an authority formed by two or more local governments, that provides firefighting and fire prevention services, emergency medical services, ambulance services, or search and rescue services, or a not-for-profit nongovernmental entity organized for the purpose of providing any of those services through the use of bona fide volunteers.

(20) "Enrollee" means:

(a) An individual who is or has been enrolled in a health maintenance organization;

(b) An individual who is or has been enrolled in an individual or group prepaid dental care plan as a principal subscriber and includes the individual's dependents who are entitled to prepaid dental care services under the plan solely because of their status as dependents of the principal subscriber; or

(c) An individual who is or has been enrolled in a health coverage plan.

(21) "Enrollee coverage" means a health coverage plan issued pursuant to this article to an enrollee setting out the coverage to which the enrollee is entitled under the health coverage plan.

(22) (a) "Essential health benefits" has the same meaning as set forth in section 1302 (b) of the federal "Patient Protection and Affordable Care Act", as amended, Pub.L. 111-148;

(b) "Essential health benefits" includes:

(I) Ambulatory patient services;

(II) Emergency services;

(III) Hospitalization;

(IV) Laboratory services;

(V) Maternity and newborn care;

(VI) Behavioral, mental health, and substance use disorder services, including behavioral health treatment;

(VII) Pediatric services, including oral and vision care;

(VIII) Prescription drugs;

(IX) Preventive and wellness services and chronic disease management; and

(X) Rehabilitative and habilitative services and devices.

(23) "Essential health benefits package" means the essential health benefits package required under section 1302 (a) of the federal act and includes coverage that:

(a) Provides for the essential health benefits;

(b) Limits cost sharing for this coverage in accordance with section 1302 (c) of the federal act; and

(c) For individual and small employer health benefit plans, provides bronze, silver, gold, or platinum levels of coverage described in section 1302 (d) of the federal act, as specified in section 10-16-103.4.

(24) "Established geographic service area" means the entire state of Colorado or, for plans that do not cover the entire state, any county within which the carrier is authorized to have arrangements established with providers to provide services.

(25) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee by a health maintenance organization setting out the coverage to which the enrollee is or was entitled.

(26) "Exchange" means the Colorado health benefit exchange created in article 22 of this title.

(27) "Executive director" means the executive director of the department of public health and environment.

(27.5) "FDA" means the food and drug administration in the United States department of health and human services, or any successor entity.

(28) "Federal act" means the federal "Patient Protection and Affordable Care Act", Pub.L. 111-148, as amended by the federal "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152, and as may be further amended, including any federal regulations adopted under the federal act.

(29) "Federal law" includes the federal act, PHA, HIPAA, EISA, and any federal regulation implementing these federal acts.

(30) "Government plan" has the same meaning as set forth in 29 U.S.C. sec. 1002 (32) of the federal "Employee Retirement Income Security Act of 1974", and as in any federal governmental plan.

(31) "Grandfathered health benefit plan" means a health benefit plan provided to an individual or employer by a carrier on or before March 23, 2010, for as long as it maintains that status in accordance with federal law and includes any extension of coverage under an individual or employer health benefit plan that existed on or before March 23, 2010, to a dependent of an individual enrolled in the plan or to a new employee and his or her dependents who enroll in the employer health benefit plan. This article, as it existed prior to May 13, 2013, applies to grandfathered health benefit plans on and after May 13, 2013.

(32) (a) "Health benefit plan" means any hospital or medical expense policy or certificate, hospital or medical service corporation contract, or health maintenance organization subscriber contract or any other similar health contract subject to the jurisdiction of the commissioner available for use, offered, or sold in Colorado.

(b) "Health benefit plan" does not include:

(I) Accident only;

(II) Credit;

(III) Dental;

(IV) Vision;

(V) Medicare supplement;

(VI) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(VII) Disability income insurance;

(VIII) Liability insurance including general liability insurance and automobile liability insurance;

(IX) Coverage for on-site medical clinics;

(X) Coverage issued as a supplement to liability insurance, workers' compensation, or similar insurance;

(XI) Automobile medical payment insurance; or

(XII) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(c) Solely with respect to section 10-16-118, "health benefit plan" excludes individual short-term limited duration health insurance policies.

(33) "Health-care services" means any services included in or incidental to the furnishing of medical, behavioral, mental health, or substance use disorder; dental, or optometric care; hospitalization; or nursing home care to an individual, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human physical illness or injury, or behavioral, mental health, or substance use disorder. "Health-care services" includes the rendering of the services through the use of telehealth, as defined in section 10-16-123 (4)(e).

(34) "Health coverage plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health-care services.

(35) "Health maintenance organization" means any person who:

(a) Provides, either directly or through contractual or other arrangements with others, health-care services to enrollees; and

(b) Provides, either directly or through contractual or other arrangements with other persons, health-care services, including, at a minimum, emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services; and

(c) Is responsible for the availability, accessibility, and quality of the health-care services provided or arranged.

(36) "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 individual or the employees of the employer.

(37) "Health-status-related factor" means any of the following factors:

(a) Health status;

(b) Medical condition, including both physical illnesses and mental health disorders;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(h) Disability.

(38) "Hearing aid" means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. "Hearing aid" includes any parts or ear molds.

(38.3) "HIPAA" means the federal "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191.

(38.5) "HIV prevention drug" means preexposure prophylaxis, post-exposure prophylaxis, or other drugs approved by the FDA for the prevention of HIV infection.

(39) "Index rate" means the premium rate established for a market segment based on the total combined claims costs for providing essential health benefits within the single risk pool of that market segment.

(40) "Intermediary" means a person authorized by health-care providers to negotiate and execute provider contracts with carriers on behalf of such providers.

(40.5) (a) **[*Editor's note: This version of the introductory portion to subsection (40.5)(a) is effective until January 1, 2026.*]** "Large employer" means any person, firm, corporation, partnership, or association that:

(40.5) (a) **[*Editor's note: This version of the introductory portion to subsection (40.5)(a) is effective January 1, 2026.*]** "Large employer" means any person that:

(I) Is actively engaged in business;

(II) **[*Editor's note: This version of subsection (40.5)(a)(II) is effective until January 1, 2026.*]** Employed an average of more than one hundred eligible employees on business days during the immediately preceding calendar year, except as provided in subsection (40.5)(c) of this section; and

(II) **[*Editor's note: This version of subsection (40.5)(a)(II) is effective January 1, 2026.*]** Employed an average of more than fifty eligible employees on business days during the immediately preceding calendar year, except as provided in subsection (40.5)(c) of this section; and

(III) Was not formed primarily for the purpose of purchasing insurance.

(b) For purposes of determining whether an employer is a "large employer", the number of eligible employees is calculated using the method set forth in 26 U.S.C. sec. 4980H (c)(2)(E).

(c) In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether the employer is a large employer is based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(d) The following employers are single employers for purposes of determining the number of employees:

(I) A person or entity that is a single employer pursuant to 26 U.S.C. sec. 414 (b), (c), (m), or (o); and

(II) An employer and any predecessor employer.

(41) "Licensed health-care provider" has the same meaning as in section 10-4-601.

(42) "Local government" means any city, county, city and county, special district, or other political subdivision of this state.

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

(43.5) "MHPAEA" means the federal "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008", Pub.L. 110-343, as amended, and all of its implementing and related regulations.

(44) "Minor child" means any person under eighteen years of age.

(45) "Network" means a group of participating providers providing services to a managed care plan. For the purposes of part 7 of this article, any subdivision or subgrouping of a network is considered a network if covered individuals are restricted to the subdivision or subgrouping for covered benefits under the managed care plan.

(46) "Participating provider" means a provider, either within or outside of Colorado, that, under a contract with a carrier or with its contractor or subcontractor, has agreed to provide health-care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from the carrier.

(47) "Patient with diabetes" means a person with elevated blood glucose levels who has been diagnosed as having diabetes by an appropriately licensed health-care professional.

(48) "Person" means any individual, partnership, association, trust, or corporation and includes any hospital licensed or certified in this state, independent practice association of physicians, or professional service corporation for the practice of medicine.

(48.5) "PHA" means the federal "Public Health Service Act", 42 U.S.C. sec. 201 et seq.

(49) (a) "Pharmacy benefit management firm", "pharmacy benefit manager", or "PBM" means any entity doing business in this state that administers or manages prescription drug benefits, including claims processing services and other prescription drug or device services as defined in section 10-16-122.1, on behalf of any carrier that provides prescription drug benefits to residents of this state, either pursuant to a contract with the carrier or as an entity that is related to, associated by common or other ownership with, or otherwise associated with the carrier.

(b) "Pharmacy benefit management firm", "pharmacy benefit manager", or "PBM" does not include:

(I) A health-care facility licensed or certified by the department of public health and environment pursuant to section 25-1.5-103 (1)(a);

(II) A provider;

(III) A consultant who only provides advice as to the selection or performance of a pharmacy benefit management firm; or

(IV) A nonprofit health maintenance organization that offers managed care plans that provide a majority of covered professional services through a single, contracted medical group and that operates its own pharmacies.

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

(50.5) "Post-exposure prophylaxis" means a drug or drug combination that meets the same clinical eligibility recommendations provided in CDC guidelines, as defined in section 12-280-125.7.

(50.7) "Preexposure prophylaxis" means a drug or drug combination that meets the same clinical eligibility recommendations provided in CDC guidelines, as defined in section 12-280-125.7.

(51) "Premium" means all moneys paid as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.

(52) "Prepaid dental care plan" means any contractual arrangement through an entity organized pursuant to part 5 of this article to provide, either directly or through arrangements with others, dental care services to enrollees on a fixed prepayment basis or as a benefit of the enrollees' participation or membership in any other contract, agreement, or group.

(53) "Prepaid dental care plan organization" means any person who undertakes to conduct one or more prepaid dental care plans providing only dental care services.

(54) "Prepaid dental care services" means services included in the practice of dentistry, as defined in article 220 of title 12, that are provided to enrollees under a prepaid dental care plan.

(55) "Producer" means a person licensed by the division who solicits, negotiates, effects, procures, delivers, renews, continues, services, or binds health benefit plans and is licensed to conduct these activities in Colorado.

(56) "Provider" means any physician, dentist, optometrist, anesthesiologist, hospital, X ray, laboratory and ambulance service, or other person who is licensed or otherwise authorized in this state to furnish health-care services.

(57) "Rate increase" means an increase in the current rate.

(58) "Rating period" means the calendar period for which premium rates established by a carrier are assumed to be in effect.

(59) "Restricted network provision" means any provision of an individual or group health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health-care providers that have entered into a contractual arrangement with the carrier to provide health-care services to covered individuals.

(59.5) "Rural independent pharmacy" means a prescription drug outlet that is privately owned by at least one licensed pharmacist with no ownership interest by or affiliation with a chain pharmacy or a publicly traded prescription drug outlet.

(60) "Short-term limited duration health insurance policy" or "short-term policy" means a nonrenewable individual health benefit plan with a specified duration of not more than six months that meets the following requirements:

(a) The policy is issued only to individuals who have not had more than one short-term policy providing the same or similar nonrenewable coverage from any carrier within the past twelve months and so states in all marketing materials, application forms, and policy forms. An applicant is eligible for coverage if a short-term carrier includes in its application form the following:

Have you or any other person to be insured been covered under two or more nonrenewable short-term policies during the past twelve months? If "yes", then this policy cannot be issued. You must wait six months from the date of your last such policy to apply for a short-term policy.

(b) The policy contains the following disclosure in ten-point or larger, bold-faced type in all marketing materials, application forms, and policy forms:

This policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health-care professional, or taken prescription drugs within twelve months before the effective date of this policy will not be covered under this policy.

(61) (a) Repealed.

(b) **[*Editor's note: This version of the introductory portion to subsection (61)(b) is effective until January 1, 2026.*]** Effective January 1, 2016, "small employer" means any person, firm, corporation, partnership, or association that:

(b) **[*Editor's note: This version of the introductory portion to subsection (61)(b) is effective January 1, 2026.*]** "Small employer" means any person that:

(I) Is actively engaged in business;

(II) **[*Editor's note: This version of subsection (61)(b)(II) is effective until January 1, 2026.*]** Employed an average of at least one but not more than one hundred eligible employees on business days during the immediately preceding calendar year, except as provided in paragraph (e) of this subsection (61); and

(II) **[*Editor's note: This version of subsection (61)(b)(II) is effective January 1, 2026.*]** Employed an average of at least one but not more than fifty eligible employees on business days during the immediately preceding calendar year, except as provided in subsection (61)(e) of this section; and

(III) Was not formed primarily for the purpose of purchasing insurance.

(c) For purposes of determining whether an employer is a "small employer", the number of eligible employees is calculated using the method set forth in 26 U.S.C. sec. 4980h (c)(2)(E).

(d) In order to be classified as a small employer with more than one employee when only one employee enrolls in the small employer's health benefit plan, the small employer shall submit to the small employer carrier the two most recent quarterly employment and tax statements substantiating that the employer had two or more eligible employees. Such small employer group shall also meet the participation requirements of the small employer carrier.

(e) In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether the employer is a small employer is based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(f) The following employers are single employers for purposes of determining the number of employees:

(I) A person or entity that is a single employer pursuant to 26 U.S.C. sec. 414 (b), (c), (m), or (o); and

(II) An employer and any predecessor employer.

(62) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

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

(64) "Standing referral" means a referral by the covered person's primary care provider to a specialist or specialized treatment center participating in the carrier's network for ongoing treatment of a covered person.

(65) "Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education, as defined in the "Higher Education Act of 1965", and a health carrier and provided to students enrolled in that institution of higher education and their dependents, that:

(a) Does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education;

(b) Does not condition eligibility for health insurance coverage on any health-status-related factor related to a student or a dependent of a student; and

(c) Meets any additional requirement that may be imposed by law.

(66) "Targeted loss ratio" means the ratio of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage to the expected earned premium over the same period. The anticipated loss ratio shall be calculated on an incurred basis as the ratio of expected incurred losses to expected earned premium.

(67) "Uncovered expenditures" means the costs of those health-care services:

(a) That are covered under the health maintenance organization's health-care plans but are not guaranteed, insured, or assumed by a person or organization other than the health maintenance organization; or

(b) For which a provider has not agreed to hold enrollees harmless if the provider is not paid by the health maintenance organization.

(68) "Valid multistate association" means an association that has:

(a) Been in active existence for at least five years;

(b) Been organized and maintained in good faith for purposes other than to obtain insurance;

(c) A minimum of five hundred members;

(d) A constitution, charter, or bylaws that provide for regular meetings, at least annually, to further the purposes of the members;

(e) Collected dues or solicited contributions for members; and

(f) Provided the members with voting privileges and representation on the governing board and committees.

(69) "Waiting period" means, with respect to a group health benefit plan and an individual that is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual, as determined by the plan sponsor, before the individual is eligible to be covered for benefits under the terms of the plan.

Source: L. 92: Entire article R&RE, p. 1617, § 1, effective July 1. **L. 93:** (3) amended, p. 200, § 1, effective March 31. **L. 94:** (1) and (40) amended and (2) to (11), (13) to (15), (18), (21), (24) to (26), (28), (31), (35), (37) to (39), (41), and (42) added, p. 1896, § 6, effective July 1. **L. 96:** (6) amended, p. 392, § 1, effective July 1; (13.5), (22.5), (25.5), and (26.5) added, p. 568, § 2, effective July 1; (22.5) and (26.5) added, p. 729, § 1, effective July 1. **L. 97:** (10)(b)(II) amended, p. 117, § 1, effective March 24; (2.5), (5.5), (13.7), (24.5), and (45) added and (9), (21), (26), (37), and (43) amended, p. 630, § 3, effective May 1; (27.5) and (28.5) added, p. 1324, § 1, effective July 1. **L. 98:** (21)(b) amended, p. 373, § 1, effective April 21; (28.7) added, p. 329, § 1, effective July 1. **L. 99:** (23)(a) amended, p. 84, § 5, effective July 1; (43.5) added, p. 319, § 3, effective July 1; (6) amended, p. 225, § 1, effective August 4. **L. 2001:** (10.5) and (20.5) added and (13.7)(d) amended, pp. 1048, 1051, §§ 31, 37, effective July 1; (6)(a), IP(10)(b), and (15) amended, p. 811, § 2, effective January 1, 2002; (22) amended and (26.3) added, p. 1153, § 2, effective January 1, 2002; (29.5) added, p. 1230, § 1, effective January 1, 2002. **L. 2002:** (6)(d) added and (10)(b)(II) and (40) amended, pp. 1291, 1290, §§ 2, 1, effective January 1, 2003; (6)(d) added and (40) amended, p. 1283, §§ 2, 1, effective January 1, 2003; (11)(a)(II) and (11)(a)(III) amended and (11)(a)(IV) added, p. 331, § 2, effective January 1, 2003. **L. 2003:** (10)(b)(II) amended, p. 1988, § 20, effective May 22; (10)(b)(IV), (10)(b)(V), (10)(b)(VI), (10)(b)(VII), and (15)(c) added and (10)(c) amended, p. 1774, §§ 7, 8, 6, effective July 1. **L. 2004:** (1), (11), and (40)(a) amended, p. 980, § 3, effective August 4; (7) amended, p. 1190, § 16, effective August 4. **L. 2005:** (42) and (43) amended, p. 762, § 14, effective June 1. **L. 2007:** (13.7)(a) amended and (26)(e) added, p. 470, §§ 1, 2, effective July 1; (10)(b)(IV), (10)(b)(V), (10)(b)(VI), and (10)(b)(VII) amended, p. 1752, § 1, effective January 1, 2009. **L. 2008:** (5.3), (36.5), and (43.7) added, p. 2249, § 3, effective July 1; (5.6), (15.5), and (26.4) added, p. 578, § 1, effective August 5; (24.7) and (27.3) added, p. 2006, § 2, effective January 1, 2009. **L. 2009:** (14) and (26)(d) amended, (HB 09-1260), ch. 107, p. 439, § 3, effective July 1; (26)(e) amended and (26)(f) and (26)(g) added, (HB 09-1338), ch. 353, p. 1843, § 3, effective July 1. **L. 2010:** (26.3) amended, (HB 10-1220), ch. 197, p. 856, § 22, effective July 1. **L. 2011:** (10.3) and (36.3) added, (SB 11-128), ch. 133, p. 467, § 2, effective April 29. **L. 2013:** Entire section amended with relocations, (HB 13-1266), ch. 217, p. 903, § 1, effective May 13; (17) amended, (SB 13-011), ch. 49, p. 160, § 7, effective January 1, 2014. **L. 2015:** (33) amended, (HB 15-1029), ch. 38, p. 95, § 2, effective January 1, 2017. **L. 2017:** IP, (22)(b)(VI), and (33) amended, (SB 17-242), ch. 263, p. 1263, § 34, effective May 25; IP, (20), and (46) amended, (SB 17-249), ch. 283, p. 1548, § 18, effective June 1. **L. 2018:** (16.5) added, (HB 18-1091), ch. 74, p. 644, § 8, effective August 8; (37)(b) amended, (SB 18-091), ch. 35, p. 381, § 3, effective August 8. **L. 2019:** (43.5) added, (HB 19-1269), ch. 195, p. 2125, § 2, effective May 16; (54) amended, (HB 19-1172), ch. 136, p. 1653, § 40, effective October 1. **L. 2020:** (22)(a) and (29) amended, (HB 20-1402), ch. 216, p. 1043, § 16, effective June 30; (27.5), (38.5), (50.5), and (50.7) added, (HB 20-1061), ch. 281, p. 1374, § 1, effective July 13. **L. 2021:** (40.5) added, (HB 21-1068), ch. 439, p. 2908, § 3, effective July 6; (49) amended, (HB 21-1297), ch. 452, p. 2991, § 2, effective July 6. **L. 2023:** (38.5) amended, (SB 23-189), ch. 69, p. 254, § 1, effective April 14. **L. 2024:** IP(40.5)(a), (40.5)(a)(II), IP(61)(b), and (61)(b)(II) amended, (SB 24-073), ch. 146, p. 589, § 1, effective January 1, 2026. **L. 2025:** (17.5), (38.3), and (48.5) added and (29) amended, (SB 25-275), ch. 377, p. 2038, § 44, effective August 6; (59.5) added, (HB 25-1222), ch. 259, p. 1328, § 2, effective August 6.

Editor's note: (1) (a) The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

(b) Subsection (61)(e) and subsection (68) are similar to former §§ 10-16-105 (12) and 10-16-214 (2)(b), respectively, as they existed prior to 2013.

(2) The provisions of this section, including the amendments made by House Bill 94-1210, were renumbered in 1994 to conform to C.R.S. numbering format.

(3) Amendments to subsection (22.5) by House Bill 96-1082 and House Bill 96-1216 were harmonized.

(4) Amendments to subsection (40) by House Bill 02-1003 and House Bill 02-1013 were harmonized.

(5) Subsection (17) was numbered as subsection (14) in Senate Bill 13-011 (see L. 2013, p. 160). That provision was harmonized with this section as it appears in House Bill 13-1266.

(6) Subsection (61)(a)(II) provided for the repeal of subsection (61)(a), effective December 31, 2015. (See L. 2013, p. 903.)

(7) Subsections (40.5) and (61) are repealed when the conditions under § 10-16-105.1 (3.5)(e)(II) have occured.

(8) Section 8(2) of chapter 259 (HB 25-1222), Session Laws of Colorado 2025, provides that the act changing this section applies to conduct occurring on or after August 6, 2025.

Cross references: (1) For chapter 55 of title 10 of the United States Code, see 10 U.S.C. § 1071 et seq.; for chapter 89 of title 5 of the United States Code, see 5 U.S.C. § 8901 et seq.; for the "Higher Education Act of 1965", see 20 U.S.C. § 1001 et seq.

(2) For the legislative declaration contained in the 1996 act enacting subsections (13.5), (22.5), (25.5), and (26.5), see section 1 of chapter 122, Session Laws of Colorado 1996. For the legislative declaration contained in the 1997 act enacting subsections (2.5), (5.5), (13.7), (24.5), and (45) and amending subsections (9), (21), (26), (37), and (43), see section 1 of chapter 154, Session Laws of Colorado 1997. For the legislative declaration contained in the 1999 act enacting subsection (43.5), see section 1 of chapter 111, Session Laws of Colorado 1999. For the legislative declaration contained in the 2001 act amending subsection (22) and enacting subsection (26.3), see section 1 of chapter 300, Session Laws of Colorado 2001. For the legislative declaration contained in the 2002 act amending subsections (11)(a)(II) and (11)(a)(III) and enacting subsection (11)(a)(IV), see section 1 of chapter 117, Session Laws of Colorado 2002. For the legislative declaration in the 2011 act adding subsections (10.3) and (36.3), see section 1 of chapter 133, Session Laws of Colorado 2011. For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in SB 18-091, see section 1 of chapter 35, Session Laws of Colorado 2018. For the legislative declaration in HB 21-1068, see section 1 of chapter 439, Session Laws of Colorado 2021. For the legislative declaration in HB 21-1297, see section 1 of chapter 452, Session Laws of Colorado 2021. For the legislative declaration in HB 25-1222, see section 1 of chapter 259, Session Laws of Colorado 2025.

(3) In 2008, subsections (5.3), (36.5), and (43.7) were enacted by the "Fair Accountable Insurance Rates Act". For the short title and legislative declaration, see sections 1 and 2 of chapter 439, Session Laws of Colorado 2008.

(4) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

10-16-103. Proposal of mandatory health-care coverage provisions. (1) Every person or organization which seeks legislative action which would mandate a health coverage or offering of a health coverage by an insurance carrier, nonprofit hospital and health-care service corporation, health maintenance organization, or prepaid dental care plan organization as a component of individual or group policies shall submit a report to the legislative committee of reference addressing both the social and financial impacts of such coverage, including the efficacy of the treatment or service proposed.

(2) Guidelines for assessing the impact of proposed mandated or mandatorily offered health coverage to the extent that information is available shall include, but not be limited to, the following:

(a) The social impact of such mandatory coverage, including, but not limited to, the following:

(I) The extent to which the treatment or service is generally utilized by a significant portion of the population;

(II) The extent to which the insurance coverage is already generally available to the general population;

(III) The extent to which the lack of coverage results in persons avoiding necessary health-care treatments;

(IV) The extent to which the lack of coverage results in unreasonable financial hardship;

(V) The level of public demand for the treatment or service, including the public level of demand for insurance coverage of such treatment or service;

(VI) The level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts;

(b) The financial impact of such mandatory coverage, including, but not limited to, the following:

(I) The extent to which the coverage will increase or decrease the cost of the treatment or service;

(II) The extent to which the coverage will increase the appropriate use of the treatment or service;

(III) The extent to which the mandated treatment or service will be a substitute for more expensive treatment or coverage;

(IV) The extent to which the coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders;

(V) The impact of this coverage on the total cost of health care in Colorado.

Source: L. 92: Entire article R&RE, p. 1620, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-125 as it existed prior to 1992.

10-16-103.3. Commission on mandated health insurance benefits - cash fund - purpose - creation - duties - repeal. (Repealed)

Source: L. 2003: Entire section added, p. 1791, § 1, effective May 20. **L. 2005:** (9) amended, p. 1026, § 1, effective June 2. **L. 2007:** (1)(b) amended, p. 176, § 4, effective March 22. **L. 2008:** (10) added, p. 2076, § 4, effective June 3.

Editor's note: Subsection (9) provided for the repeal of this section, effective July 1, 2010. (See L. 2005, p. 1026.)

10-16-103.4. Essential health benefits - requirements - rules. (1) Carriers offering individual or small group health benefit plans in this state shall ensure that the coverage includes the essential health benefits package. This subsection (1) does not apply to grandfathered health benefit plans.

(2) Except as provided in subsection (3) of this section, carriers subject to subsection (1) of this section shall offer health benefit plans that provide at least one of the following levels of coverage:

(a) **Bronze level.** A health benefit plan in the bronze level provides a level of coverage designed to provide benefits actuarially equivalent to sixty percent of the full actuarial value of the benefits provided under the plan.

(b) **Silver level.** A health benefit plan in the silver level provides a level of coverage designed to provide benefits actuarially equivalent to seventy percent of the full actuarial value of the benefits provided under the plan.

(c) **Gold level.** A health benefit plan in the gold level provides a level of coverage designed to provide benefits actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under the plan.

(d) **Platinum level.** A health benefit plan in the platinum level provides a level of coverage designed to provide benefits actuarially equivalent to ninety percent of the full actuarial value of the benefits provided under the plan.

(3) A carrier that offers an individual health benefit plan that does not provide a bronze, silver, gold, or platinum level of coverage, as described in subsection (2) of this section, meets the requirements of this section with respect to any policy year if the plan is a catastrophic plan, as defined in section 10-16-102 (10).

(4) If a carrier subject to subsection (1) of this section offers an individual health benefit plan in any level of coverage specified in subsection (2) of this section, the carrier shall also offer coverage in that level as child-only coverage.

(5) A carrier subject to subsection (1) of this section shall ensure that the annual cost-sharing and annual deductible limitations imposed under the health benefit plan it offers do not exceed the limitations under federal law.

(6) **Exclusion.** This section does not apply to stand-alone dental plans offered separately or in conjunction with a health benefit plan.

(7) The commissioner may adopt rules as necessary for the implementation and administration of this section and to ensure consistent requirements for pediatric dental benefits under this section regardless of the method by which a health benefit plan is purchased.

Source: L. 2013: Entire section added, (HB 13-1266), ch. 217, p. 919, § 2, effective May 13. **L. 2014:** (7) amended, (HB 14-1053), ch. 7, p. 89, § 1, effective February 19.

10-16-103.5. Payment of premiums - required term in contract - rules - definition. (1) (a) Every contract for a health benefit plan between a carrier and a policyholder shall require the policyholder to pay premiums for each individual covered under the policyholder's policy:

(I) Through the date that the policyholder notifies the carrier that the individual covered under the policy is no longer eligible or covered;

(II) Through the date that the policyholder notifies the carrier that the policyholder no longer intends to maintain coverage for the group through the carrier; or

(III) Through the date that the individual covered under the policy is no longer eligible or covered if the policyholder notifies the carrier within ten business days after the date that the individual is no longer eligible or covered because the individual left employment without notice to the employer or the individual is an employee whose employment was terminated for gross misconduct.

(b) Subsection (1)(a)(III) of this section does not apply if a dependent is no longer covered because the dependent becomes enrolled in the children's basic health plan, established pursuant to article 8 of title 25.5. If the dependent becomes enrolled in the children's basic health plan, the policyholder shall notify the carrier of the change in coverage at least thirty days prior to the date that the dependent is no longer covered.

(c) If the policyholder notifies the carrier within the ten-day period pursuant to subsection (1)(a)(III) of this section, the carrier is not required to provide benefits to the individual after the date that the individual is no longer eligible or covered under the policy, unless the individual elects to continue health insurance coverage pursuant to the federal "Consolidated Omnibus Budget Reconciliation Act of 1985", 29 U.S.C. sec. 1161 et seq., as amended, or section 10-16-108.

(d) Nothing in this subsection (1) precludes a carrier and policyholder from agreeing to a date other than a date specified in subsection (1)(a)(III) of this section.

(e) The commissioner may promulgate rules concerning the eligibility notifications in this subsection (1) in order to ensure consistency among policyholders and carriers.

(f) For the purposes of this subsection (1), "gross misconduct" means a deliberate wrongdoing by the employee that fundamentally undermines the relationship of trust and confidence between the employer and employee.

(2) Premiums shall be paid according to the premium payment provisions of the contract. The carrier shall include in the contract, in the billing notice, or in the application process for coverage, an option for the policyholder to make monthly premium payments and an option to make premium payments by automatic electronic transfer.

Source: L. 2002: Entire section added, p. 887, § 3, effective January 1, 2003. **L. 2005:** (2) amended, p. 345, § 2, effective December 31. **L. 2007:** (1)(a) amended, p. 471, § 3, effective July 1. **L. 2019:** (1) amended, (SB 19-041), ch. 85, p. 300, § 1, effective August 2.

10-16-103.6. Copayment-only prescription payment structures - required inclusion in health benefit plans - rules. (1) (a) In addition to the requirements in section 10-16-103.4 (2), for health benefit plans issued or renewed on or after January 1, 2023, each carrier that offers an individual or small group health benefit plan shall offer at least twenty-five percent of its health benefit plans on the exchange and at least twenty-five percent of its plans not on the

exchange in each bronze, silver, gold, and platinum benefit level in each service area as copayment-only payment structures for all prescription drug cost tiers.

(b) For each copayment-only payment structure for prescription drugs:

(I) The copayment amount for the highest prescription drug cost tier must not be greater than one-twelfth of the health benefit plan's out-of-pocket maximum amount;

(II) The copayment amounts between the two highest prescription drug cost tiers must have a cost difference of at least ten percent;

(III) No more than fifty percent of the drugs on the prescription drug formulary used to treat a specific condition may be placed on the highest prescription drug cost tier; and

(IV) Each carrier shall use "Rx Copay" at the end of the marketing names for each copayment-only payment structure.

(2) The commissioner may promulgate rules to implement and enforce this section.

Source: L. 2022: Entire section added, (HB 22-1370), ch. 184, p. 1228, § 1, effective August 10.

10-16-104. Mandatory coverage provisions - applicability - rules - definitions. (1) **Newborn children.** (a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(b) (I) Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(II) Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(III) The provisions of subparagraphs (I) and (II) of this paragraph (b) shall not apply in any case in which the decision to discharge the newborn prior to the minimum length of stay otherwise required under subparagraphs (I) and (II) of this paragraph (b) is made by an attending provider with the agreement of the mother.

(IV) Nothing in this paragraph (b) shall be construed to require a mother who is a participant or beneficiary to give birth in a hospital or to stay in the hospital for a fixed period of time after the birth of her child.

(V) Nothing in this paragraph (b) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan; except that such coinsurance or other cost sharing for any portion of a period within a hospital length of stay required under subparagraphs (I) and (II) of this paragraph (b) may not be greater than such coinsurance or cost sharing for any other sickness, injury, disease, or condition that is otherwise covered under the policy or contract.

(c) (I) Except as provided for cleft lip and cleft palate coverage in sub-subparagraph (A) of subparagraph (II) of this paragraph (c) and for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist pursuant to sub-

subparagraph (A) of subparagraph (III) of this paragraph (c), the benefits available to newborn children shall consist of coverage of injury or sickness, including all medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities for the first thirty-one days of the newborn's life, notwithstanding policy limitations and exclusions applicable to other conditions or procedures covered by the policy. Except as provided in sub-subparagraph (C) of subparagraph (II) of this paragraph (c), such coverage shall be subject to copayment, deductible, and aggregate dollar policy maximums that are no higher than are generally applicable under the policy to all other sicknesses, diseases, and conditions otherwise covered under the policy.

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

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

(C) If a dental insurance policy, a contract for dental insurance, or an enrollee coverage contract issued pursuant to this article is in effect at the time of the birth, or is purchased after the birth, of a child with cleft lip or cleft palate or both, it shall provide fully for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both. Such policy or contract may contain the same copayment provisions for the coverage of cleft lip or cleft palate or both as apply to other conditions or procedures covered by the policy or contract.

(III) (A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic acidemia; immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription.

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

(C) As used in this subparagraph (III), "medical foods" means prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of

inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

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

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

(e) The requirements of this section shall apply to all individual sickness and accident policies issued on and after July 1, 1975, and to all blanket and group sickness and accident policies issued, renewed, or reinstated on and after July 1, 1975, and to all subscriber or enrollee coverage contracts delivered or issued for delivery in this state on and after July 1, 1975.

(f) (I) Any contract of a prepaid dental plan of an entity subject to the provisions of part 5 of this article applied for that provides family coverage shall, as to such coverage of individuals in the family, also provide that the benefits applicable for children shall be payable with respect to a newly born child of the insured from the instant of such child's birth to the same extent that such coverage applies to other individuals in the family. If payment of a specific premium or capitation amount is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium or capitation amount shall be furnished to the organization within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.

(II) The coverage for newborn children shall include any orthodontics or dental care needed as the result of the child being born with a cleft lip or cleft palate or both. The contract providing such coverage may contain the same copayment provisions as apply to other conditions or procedures covered by the contract.

(g) The health-care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (1) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(1.3) **Early intervention services.** (a) As used in this subsection (1.3), unless the context otherwise requires:

(I) "Division" means the unit within the department of human services that is responsible for developmental disabilities services.

(II) "Early intervention services" means services as defined by the division in accordance with part C that are authorized through an eligible child's IFSP but that exclude

nonemergency medical transportation; respite care; service coordination, as defined in 34 CFR 303.12 (d)(11); and assistive technology, unless assistive technology is covered under the applicable insurance policy or service or indemnity contract as durable medical equipment.

(III) "Eligible child" means an infant or toddler, from birth through two years of age, who is an eligible dependent and who, as defined by the department pursuant to section 26.5-3-402 (11), has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to section 27-10.5-102 (11)(c).

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

(V) "Part C" means the early intervention program for infants and toddlers who are eligible for services under part C of the federal "Individuals with Disabilities Education Act", 20 U.S.C. sec. 1400 et seq.

(VI) "Qualified early intervention service provider" or "qualified provider" means a person or agency, as defined by the division in accordance with part C, who provides early intervention services and is listed on the registry of early intervention service providers pursuant to section 26.5-3-408 (1).

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

(II) (A) The coverage required by this subsection (1.3) must be available annually to an eligible child from birth up to the child's third birthday for early intervention services for each dependent child per calendar or policy year. The commissioner shall specify, by rule, the extent of the coverage for early intervention services required by this subsection (1.3), which, except for grandfathered health benefit plans, must require coverage of a number of early intervention services or visits that is actuarially equivalent to the dollar limit of the benefit as it existed prior to May 13, 2013.

(B) For grandfathered health benefit plans, the coverage required by this subsection (1.3) per calendar or policy year for early intervention services for each eligible dependent child from birth up to the child's third birthday is limited to six thousand three hundred sixty-one dollars, including case management costs. Effective January 1, 2014, and each January 1 thereafter, the commissioner shall annually adjust the dollar limit for early intervention services coverage based on the Denver-Aurora-Lakewood consumer price index or, if applicable, its predecessor or successor index for the state fiscal year that ends in the immediately preceding calendar year, or by an additional amount equal to the increase by the general assembly in the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that increase is more than the consumer price index increase.

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

(IV) Any limit on the amount of coverage for early intervention services specified by the commissioner by rule pursuant to sub-subparagraph (A) of subparagraph (II) of this paragraph (b) or, for grandfathered health benefit plans, specified in sub-subparagraph (B) of subparagraph (II) of this paragraph (b) shall not apply to:

(A) Rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation;

(B) Services provided to a child who is not participating in part C and services that are not provided pursuant to an IFSP. However, such services shall be covered at the level specified in paragraph (b) of subsection (1.7) of this section.

(c) This subsection (1.3) shall not apply to the following:

(I) Short-term, accident, fixed indemnity, or specified disease policies, disability income contracts, limited benefit health insurance, as defined by the commissioner by rule, credit disability insurance, or a medicare supplement policy as defined in section 10-18-101 (4);

(II) Workers' compensation or similar insurance;

(III) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and required by law to be contained in any liability insurance policy or equivalent self-insurance.

(d) (I) The coverage required by this subsection (1.3) may be offered through a high deductible plan that would qualify for a health savings account pursuant to 26 U.S.C. sec. 223; except that a carrier may apply deductible amounts for the required coverage if it is not considered by the United States department of treasury to be preventive or to have an acceptable deductible amount.

(II) If a high deductible plan that would qualify for a health savings account pursuant to 26 U.S.C. sec. 223 requires a deductible or copayment amount for the coverage required by this subsection (1.3), the deductible or copayment amount may be paid by the state as determined by rules adopted by the commissioner in accordance with article 4 of title 24, C.R.S., in consultation with the division of insurance.

(d.5) (I) Upon notice from the department of early childhood pursuant to section 26.5-3-409 (1) that a child is eligible for early intervention services, the carrier shall submit payment of benefits for the eligible child in accordance with this subsection (1.3)(d.5)(I) and section 26.5-3-409 (1). If the eligible child is covered by a grandfathered health benefit plan, the carrier shall submit payment in the amount specified in subsection (1.3)(b)(II)(B) of this section, as adjusted annually pursuant to said subsection. If the eligible child is covered by any other policy or contract subject to this subsection (1.3), the carrier shall submit payment in an amount that equals the approximate value of the number of early intervention services or visits specified by the commissioner pursuant to subsection (1.3)(b)(II)(A) of this section.

(II) Qualified early intervention service providers that receive reimbursement in accordance with this paragraph (d.5) shall accept the reimbursement as payment in full for

services provided under this subsection (1.3) and shall not seek additional reimbursement from either the covered person or the carrier.

(e) Within ninety days after the division determines that a child is no longer an eligible child for purposes of this subsection (1.3), the division shall notify the carrier that the child is no longer eligible and that the carrier is no longer required to provide the coverage required by this subsection (1.3) for that child.

(f) Use of available coverage under this subsection (1.3) for the cost of early intervention services is mandatory, consistent with the requirements of part C. An eligible child must fully utilize available coverage under this subsection (1.3) prior to accessing state general funds or federal part C funds. A carrier shall not terminate or fail to renew health coverage on the basis that an eligible child has accessed or will be accessing early intervention services under this subsection (1.3).

(g) Early intervention services shall be provided as specified in the eligible child's IFSP, and such services shall not duplicate or replace treatment for autism spectrum disorders provided in accordance with subsection (1.4) of this section. Services for the treatment of autism spectrum disorders provided in accordance with subsection (1.4) of this section shall be considered the primary service to an eligible child, and early intervention services provided under this subsection (1.3) shall supplement, but not replace, services provided under subsection (1.4) of this section.

(1.4) **Autism spectrum disorders.** (a) As used in this subsection (1.4), unless the context otherwise requires:

(I) "Applied behavior analysis" means the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

(II) "Autism services provider" means any person who provides direct services to a person with autism spectrum disorder, is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized organization, and meets one of the following:

(A) Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the Colorado medical board, and has at least one year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism spectrum disorders;

(B) Has a doctoral degree in one of the behavioral or health sciences and has completed one year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism spectrum disorders;

(C) Has a master's degree or higher in behavioral sciences and is nationally certified as a "board certified behavior analyst" or certified by a similar nationally recognized organization;

(D) Has a master's degree or higher in one of the behavior or health sciences, is credentialed as a related services provider, and has completed one year of direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism spectrum disorders. For the purposes of this sub-subparagraph (D), "related services provider" means a physical therapist, occupational therapist, or speech therapist.

(E) Has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a "board certified associate behavior analyst" by the behavior analyst certification board or by a similar nationally recognized organization; or

(F) Is nationally registered as a "registered behavior technician" by the behavior analyst certification board or by a similar nationally recognized organization and provides direct services to a person with an autism spectrum disorder under the supervision of an autism services provider described in sub-subparagraph (A), (B), (C), (D), or (E) of this subparagraph (II).

(III) "Autism spectrum disorders" or "ASD":

(A) Has the same meaning as set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis; and

(B) Includes the following disorders, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis: Autistic disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified.

(IV) "Health benefit plan", does not include:

(A) Short-term limited duration health insurance policies; or

(B) Individual grandfathered health benefit plans.

(V) "Individualized education program" shall have the same meaning as provided in section 22-20-103, C.R.S.

(VI) "Individualized family service plan" shall have the same meaning as provided in section 27-10.5-102, C.R.S.

(VII) "Individualized plan" has the same meaning as provided in section 25.5-10-202, C.R.S.

(VIII) "Pharmacy care" means medications prescribed by a physician licensed by the Colorado medical board under the "Colorado Medical Practice Act", article 240 of title 12.

(IX) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed by the Colorado medical board under the "Colorado Medical Practice Act", article 240 of title 12.

(X) "Psychological care" means direct or consultative services provided by a psychologist licensed by the state board of psychologist examiners pursuant to part 3 of article 245 of title 12 or a social worker licensed by the state board of social work examiners pursuant to part 4 of article 245 of title 12.

(XI) "Therapeutic care" means services provided by a speech therapist; an occupational therapist or occupational therapy assistant licensed to practice occupational therapy pursuant to article 270 of title 12; a physical therapist licensed to practice physical therapy pursuant to article 285 of title 12; or an autism services provider. "Therapeutic care" includes, but is not limited to, speech, occupational, and applied behavior analytic and physical therapies.

(XII) "Treatment for autism spectrum disorders" shall be for treatments that are medically necessary. The treatments listed in this subparagraph (XII) are not considered experimental or investigational and are considered appropriate, effective, or efficient for the treatment of autism. "Treatment for autism spectrum disorders" shall include the following, as medically necessary:

(A) Evaluation and assessment services;

(B) Behavior training and behavior management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for autism spectrum disorders provided by autism services providers;

(C) Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies. For a person who is also covered under subsection (1.7) of this section, the level of benefits for occupational therapy, physical therapy, or speech therapy shall exceed the limit of twenty visits for each therapy if such therapy is medically necessary to treat autism spectrum disorders under this subsection (1.4).

(D) Pharmacy care and medication, if covered by the health benefit plan;

(E) Psychiatric care;

(F) Psychological care, including family counseling; and

(G) Therapeutic care.

(XIII) "Treatment plan" means a plan developed for an individual by an autism services provider and prescribed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation for an individual consisting of the individual's diagnosis; proposed treatment by type, frequency, and anticipated treatment; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. The treatment plan shall be developed in accordance with the patient-centered medical home as defined in section 25.5-1-103 (5.5), C.R.S.

(b) (I) All health benefit plans issued or renewed in this state must provide coverage for the assessment, diagnosis, and treatment of autism spectrum disorders for a child pursuant to this subsection (1.4).

(II) Nothing in this subsection (1.4):

(A) Requires or permits a carrier to reduce benefits provided for autism spectrum disorders if a health benefit plan already provides coverage that exceeds the requirements of this subsection (1.4) and rules adopted by the commissioner;

(B) Prevents a carrier from increasing benefits provided for autism spectrum disorders; or

(C) Limits coverage for physical or mental health benefits covered under a health benefit plan.

(c) Treatment for autism spectrum disorders shall be prescribed or ordered by a licensed physician or licensed psychologist.

(d) A health benefit plan offered to residents of this state providing basic health-care services that is delivered, issued for delivery, or renewed in this state shall not exclude autism spectrum disorders or impose additional requirements for authorization of services that operate to exclude coverage for the assessment, diagnosis, and treatment of autism spectrum disorders.

(e) Except as otherwise provided in paragraph (b) of this subsection (1.4), the coverage required under this subsection (1.4) shall not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the health benefit plan. The benefits of this subsection (1.4) shall be in addition to any benefits provided for in subsections (1.3) and (1.7) of this section.

(f) Benefits provided by a carrier on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any maximum benefit amount established under this subsection (1.4).

(g) A carrier may not deny or refuse to provide otherwise covered services, refuse to issue, renew, or reissue, or otherwise restrict or terminate coverage under a health benefit plan because the individual or his or her covered dependent is diagnosed with an autism spectrum disorder or due to the individual's or dependent's utilization of services for which benefits are mandated by this subsection (1.4).

(h) Any review of a treatment plan or any appeal of a decision regarding treatment shall be subject to the rules of the commissioner on prompt investigation of health plan claims involving utilization review and denial of benefits.

(i) Nothing in this subsection (1.4) shall be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized plan. The services required to be covered by this subsection (1.4) shall be in addition to any services provided to an individual under an individualized family service plan, an individualized education program, or an individualized plan.

(j) Coverage under this subsection (1.4) is subject to all terms, conditions, definitions, restrictions, exclusions, limitations, and utilization review of health-care services that apply to any other coverage under the health benefit plan, including the treatment under the health benefit plan of services performed by participating and nonparticipating providers.

(1.5) (Deleted by amendment, L. 2009, (HB 09-1204), ch. 344, p. 1802, § 2, effective January 1, 2010.)

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

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

(c) Repealed.

(d) The health-care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (1.7) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(2) **Complications of pregnancy and childbirth.** (a) Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of this article and any individual or group service or indemnity contract issued by an entity subject to part 3 of this article shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy or contract. Any sickness and accident insurance policy providing indemnity for disability due to accident shall provide coverage for an

accident which occurs during the course of pregnancy or childbirth in the same manner as any other similar accident is covered under the policy.

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

(3) **Maternity coverage.** (a) (I) (A) All group sickness and accident insurance policies providing coverage within the state and issued to an employer by an entity subject to part 2 of this article 16, all group health service contracts issued by an entity subject to part 3 or 4 of this article 16 and issued to an employer, all individual sickness and accident insurance policies issued by an entity subject to part 2 of this article 16, and all individual health-care or indemnity contracts issued by an entity subject to part 3 or 4 of this article 16, except supplemental policies covering a specified disease or other limited benefit, must insure against the expense of normal pregnancy and childbirth or provide coverage for maternity care and provide coverage for contraception in the same manner as any other sickness, injury, disease, or condition is otherwise covered under the policy or contract; except that coverage for contraception must be consistent with the requirements in section 10-16-104.2.

(B) Individual sickness and accident insurance policies or contracts may exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition; except that the exclusion for a pregnancy as a preexisting condition under the policy or contract does not apply for any subsequent pregnancies. Group sickness and accident insurance policies or contracts must not exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition.

(II) Coverage for a hospital stay following a normal vaginal delivery shall not be limited to less than forty-eight hours. If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(III) Coverage for a hospital stay following a cesarean section shall not be limited to less than ninety-six hours. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(IV) The provisions of subparagraphs (II) and (III) of this paragraph (a) shall not apply in any case in which the decision to discharge prior to the minimum length of stay otherwise required under subparagraphs (II) and (III) of this paragraph (a) is made by an attending provider with the agreement of the mother.

(V) Nothing in this paragraph (a) shall be construed to require a mother who is a participant or beneficiary to give birth in a hospital or to stay in the hospital for a fixed period of time after the birth of her child.

(VI) Nothing in this paragraph (a) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan; except that such coinsurance or other cost sharing for any portion of a period within a hospital length of stay required under subparagraphs (II) and (III) of this paragraph (a) may not be greater than such coinsurance or cost sharing for any other sickness, injury, disease, or condition that is otherwise covered under the policy or contract.

(VII) **[*Editor's note: Subsection (3)(a)(VII) is effective January 1, 2027.*]** Except for a standardized health benefit plan offered pursuant to section 10-16-1305, for a health benefit plan

providing maternity coverage pursuant to this subsection (3) that is issued or renewed on or after January 1, 2027, the health benefit plan must provide coverage without cost sharing for up to three prenatal care office visits.

(b) The requirement in paragraph (a) of this subsection (3) shall not apply to policies or contracts purchased by employers who employ any number of full-time or part-time employees in fewer than fifteen full-time employee positions or to employers who employ any number of full-time or part-time employees for not more than six consecutive months each year on a seasonal basis if such coverage as required in paragraph (a) of this subsection (3) is provided by the employer in one of the following methods:

(I) **Self-insurance.** All employers who elect under this subparagraph (I) to utilize self-insurance for providing this benefit shall provide written notice to affected employees and to the health insurance carrier of its choice to self-insure.

(II) A policy purchased from an insurance company authorized to do business in this state which meets all of the requirements of the division of insurance for that purpose;

(III) A contract issued by an entity subject to the provisions of part 3 or 4 of this article;

(IV) A combination of the methods of obtaining insurance authorized in subparagraphs (I) to (III) of this paragraph (b).

(c) An entity authorized under the provisions of part 3 or 4 of this article to issue service or indemnity-type contracts shall offer coverage for maternity care to both married and unmarried women in individual, nonfamily contracts and shall offer the same coverage and the same payment of costs for maternity benefits to unmarried women that it offers to married women.

(d) A carrier offering a health benefit plan in the state shall reimburse participating providers who provide covered health-care services related to labor and delivery within the scope of the provider's practice in a manner that:

(I) Promotes high-quality, cost-effective, and evidence-based care;

(II) Promotes high-value, evidence-based payment models; and

(III) Prevents risk in subsequent pregnancies.

(e) **Doula services - rules - definitions.** (I) As used in this subsection (3)(e), unless the context otherwise requires:

(A) "Billing guidance" means guidance from the department of health care policy and financing concerning coverage and billing for doula services after consideration of the findings and recommendations for doula services resulting from the stakeholder process required pursuant to section 25.5-4-506.

(B) "Doula" means a trained birth companion who provides personal, nonmedical support to pregnant and postpartum people and their families prior to childbirth, during labor and delivery, and during the postpartum period and who has the qualifications and training required by the state.

(C) "Doula services" means services provided by a doula.

(D) "Medical assistance program" means the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5.

(II) In the large group market, maternity coverage pursuant to this subsection (3) must include coverage for doula services, to the extent practicable, for the same scope and duration of coverage that is included in the department of health care policy and financing's request submitted pursuant to section 25.5-4-506 for federal authorization for doula services under the

medical assistance program. The benefit may include the same qualifications for individuals providing doula services as recommended in the billing guidance for individuals providing doula services under the medical assistance program.

(III) Except as provided in subsection (3)(e)(VI) of this section, in the individual and small group markets, maternity coverage pursuant to this subsection (3) must include coverage for doula services if the services are within the doula's area of professional competence and the doula services are:

(A) Currently reimbursed when rendered by any other health-care providers; or

(B) Covered as part of the maternity essential health benefit.

(IV) This subsection (3)(e) applies to, and the division shall implement the requirements of this subsection (3)(e) for, large employer health benefit plans issued or renewed in this state on or after July 1, 2025, or twelve months after the date on which the department of health care policy and financing submits its request pursuant to section 25.5-4-506 for federal authorization for doula services under the medical assistance program, whichever is later.

(V) With respect to individual and small group health benefit plans, the division shall:

(A) Review the actuarial review conducted pursuant to section 10-16-155.5 and submit to the federal department of health and human services the division's determination as to whether the benefit specified in this subsection (3)(e) is in addition to essential health benefits and would be subject to defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); and

(B) Request that the federal department of health and human services confirm the division's determination within sixty days after receipt of the division's request and submission of its determination.

(VI) This subsection (3)(e) applies to, and the division shall implement the requirements of this subsection (3)(e) for, individual and small group health benefit plans issued or renewed in this state upon the earlier of:

(A) Twelve months after the federal department of health and human services confirms the division's determination or otherwise informs the division that the coverage specified in this subsection (3)(e) does not constitute an additional benefit that requires defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); or

(B) The passage of more than three hundred sixty-five days since the division submitted its determination and request for confirmation pursuant to subsection (3)(e)(V) of this section, and the federal department of health and human services has failed to respond to the request within that period, in which case the division shall consider the federal department's unreasonable delay a preclusion from requiring defrayal by the state.

(VII) The commissioner may promulgate rules as necessary to implement this subsection (3).

(4) (Deleted by amendment, L. 2009, (HB 09-1204), ch. 344, p. 1802, § 2, effective January 1, 2010.)

(5) Repealed.

(5.5) **Behavioral, mental health, and substance use disorders.**

(a) (I) **[*Editor's note: This version of subsection (5.5)(a)(I) is effective until January 1, 2026.*]** Every health benefit plan subject to part 2, 3, or 4 of this article 16, except those described in section 10-16-102 (32)(b), must provide coverage:

(A) For the prevention of, screening for, and treatment of behavioral, mental health, and substance use disorders that is no less extensive than the coverage provided for any physical illness and that complies with the requirements of the MHPAEA; and

(B) At a minimum, for the treatment of substance use disorders in accordance with the American Society of Addiction Medicine criteria for placement, medical necessity, and utilization management determinations as set forth in the most recent edition of "The ASAM Criteria for Addictive, Substance-related, and Co-occurring Conditions"; except that the commissioner may identify by rule, in consultation with the department of health care policy and financing and the behavioral health administration in the department of human services, an alternate nationally recognized and evidence-based substance-use-disorder-specific criteria for placement, medical necessity, or utilization management, if the American Society of Addiction Medicine criteria are no longer available or relevant or do not follow best practices for substance use disorder treatment.

(5.5) **Behavioral, mental health, and substance use disorders - utilization review criteria - federal treatment limitation requirements - meaningful benefits - rules - definitions.**

(a) (I) **[*Editor's note: This version of subsection (5.5)(a)(I) is effective January 1, 2026.*]** Every health benefit plan subject to part 2, 3, or 4 of this article 16, except those described in section 10-16-102 (32)(b), must provide coverage:

(A) For the prevention of, screening for, and treatment of behavioral, mental health, and substance use disorders that is no less extensive than the coverage provided for any physical illness, that complies with the requirements of the MHPAEA, and that does not discriminate in its benefit design against individuals because of their present or predicted behavioral, mental health, or substance use disorder;

(B) At a minimum, for the treatment of substance use disorders in accordance with the American Society of Addiction Medicine criteria for placement, medical necessity, and utilization management determinations as set forth in the most recent edition of "The ASAM Criteria: Treatment Criteria for Addictive, Substance-related, and Co-occurring Conditions"; except that the commissioner may identify by rule, in consultation with the department of health care policy and financing and the behavioral health administration in the department of human services, alternate nationally recognized and evidence-based substance-use-disorder-specific not-for-profit utilization review criteria that is consistent with generally accepted standards of substance use disorder care for placement, medical necessity, or utilization review, if the American Society of Addiction Medicine criteria are no longer available or relevant or do not follow best practices for substance use disorder treatment; and

(C) For medically necessary treatment of covered behavioral, mental health, and substance use disorder benefits, including services that are consistent with criteria, guidelines, or consensus recommendations from nationally recognized not-for-profit clinical specialty associations of the relevant behavioral, mental health, or substance use disorder specialty.

(I.5) **[*Editor's note: Subsection (5.5)(a)(I.5) is effective January 1, 2026.*]**

(A) All utilization review and utilization review criteria must be consistent with current generally accepted standards of behavioral, mental health, and substance use disorder care.

(B) In conducting utilization review of covered services for the diagnosis, prevention, and treatment of behavioral or mental health disorders, a health benefit plan shall apply the criteria and guidelines set forth in the most recent version of the treatment criteria developed by

unaffiliated nationally recognized not-for-profit clinical specialty associations of the relevant behavioral or mental health disorders. In conducting utilization review of covered services for the diagnosis, prevention, and treatment of substance use disorders, a health benefit plan shall apply the criteria specified in subsection (5.5)(a)(I)(B) of this section.

(C) In conducting utilization review relating to service intensity, level of care placement, or any other patient care decisions that are within the scope of the sources specified in subsections (5.5)(a)(I)(B) and (5.5)(a)(I.5)(B) of this section, a health benefit plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria set forth in those sources. If the requested service intensity or level of care placement is inconsistent with the health benefit plan's assessment using the relevant criteria, as part of any adverse benefit determination, the health benefit plan shall provide full detail of its assessment and the relevant criteria used in the assessment to the provider and the covered person.

(D) In conducting utilization review that is outside the scope of the criteria specified in subsections (5.5)(a)(I)(B) and (5.5)(a)(I.5)(B) of this section or related to advancements in technology or types of levels of care that are not addressed in the most recent versions of the sources specified in those subsections, a health benefit plan shall conduct utilization review in accordance with subsection (5.5)(a)(I.5)(A) of this section. If a health benefit plan purchases or licenses utilization review criteria pursuant to this subsection (5.5)(a)(I.5)(D), the health benefit plan shall verify and document before use that the criteria comply with the requirements of subsection (5.5)(a)(I.5)(A) of this section.

(E) A health benefit plan must not limit benefits or coverage for chronic behavioral, mental health, or substance use disorders to short-term symptom reduction at any level-of-care placement.

(II) (Deleted by amendment, L. 2013.)

(III) (A) Except as provided in subsections (5.5)(a)(III)(B) and (5.5)(a)(III)(C) of this section, any preauthorization or utilization review mechanism used in the determination to provide the coverage required by this subsection (5.5)(a) must be the same as, or no more restrictive than, that used in the determination to provide coverage for a physical illness. The commissioner shall adopt rules as necessary to implement and administer this subsection (5.5).

(B) A health benefit plan subject to this subsection (5.5) must provide coverage without prior authorization for a five-day supply of at least one of the FDA-approved drugs for the treatment of opioid dependence; except that this requirement is limited to a first request within a twelve-month period.

(C) A health benefit plan subject to this subsection (5.5) must provide coverage for at least one opiate antagonist, as defined in section 12-30-110 (7)(d).

(IV) In the event of a concurrent review for a claim for coverage of services for the prevention of, screening for, and treatment of behavioral, mental health, and substance use disorders, the service continues to be a covered service until the carrier notifies the covered person of the determination on the claim.

(V) A carrier offering a health benefit plan subject to the requirements of this subsection (5.5) shall:

(A) **[*Editor's note: This version of subsection (5.5)(a)(V)(A) is effective until January 1, 2026.*]** Comply with the nonquantitative treatment limitation requirements specified in 45 CFR 146.136 (c)(4), or any successor regulation, regarding any limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment, which, in

addition to the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(iii), or any successor regulation, and 78 FR 68246, include the methods by which the carrier establishes and maintains its provider networks pursuant to section 10-16-704 and responds to deficiencies in the ability of its networks to provide timely access to care;

(A) **[*Editor's note: This version of subsection (5.5)(a)(V)(A) is effective January 1, 2026.*]** Comply with the nonquantitative treatment limitation requirements specified in 45 CFR 146.136 or 29 CFR 2590.712, or any successor regulation, regarding any limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment, which, in addition to the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and (c)(4)(vi) or 29 CFR 2590.712 (c)(4)(ii) and (c)(4)(vi), or any successor regulation, and 78 Fed. Reg. 68246 (November 13, 2013) and 89 Fed. Reg. 77586 (September 23, 2024), include the methods by which the carrier establishes and maintains its provider networks pursuant to section 10-16-704 and responds to deficiencies in the ability of its networks to provide timely access to care;

(B) **[*Editor's note: This version of subsection (5.5)(a)(V)(B) is effective until January 1, 2026.*]** Comply with the financial requirements and quantitative treatment limitations specified in 45 CFR 146.136 (c)(2) and (c)(3), or any successor regulation;

(B) **[*Editor's note: This version of subsection (5.5)(a)(V)(B) is effective January 1, 2026.*]** Comply with the financial requirements and quantitative treatment limitations specified in 45 CFR 146.136 (c)(2) and (c)(3) or any successor regulation or 29 CFR 2590.712 (c)(2) and (c)(3);

(C) Not apply any nonquantitative treatment limitations to benefits for behavioral, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits;

(D) **[*Editor's note: This version of subsection (5.5)(a)(V)(D) is effective until January 1, 2026.*]** Establish procedures to authorize treatment with a nonparticipating provider if a covered service is not available within established time and distance standards and within a reasonable period after a service is requested, and with the same coinsurance, deductible, or copayment requirements as would apply if the services were provided by a participating provider, and at no greater cost to the covered person than if the services were obtained at or from a participating provider; and

(D) **[*Editor's note: This version of subsection (5.5)(a)(V)(D) is effective January 1, 2026.*]** Establish procedures to authorize medically necessary treatment with an appropriate nonparticipating provider and to provide services to make available the covered service if a covered service is not available within established time and distance standards, and within a reasonable period, after a service is requested, and with the same coinsurance, deductible, or copayment requirements, accruing to in-network annual cost-sharing limits, as would apply if the services were provided by a participating provider, and at no greater cost to the covered person than if the services were obtained at or from a participating provider;

(E) If a covered person obtains a covered service from a nonparticipating provider because the covered service is not available within established time and distance standards, reimburse treatment or services for behavioral, mental health, or substance use disorders required to be covered pursuant to this subsection (5.5) that are provided by a nonparticipating provider using the same methodology the carrier uses to reimburse covered medical services provided by nonparticipating providers and, upon request, provide evidence of the methodology to the covered person or provider.

(F) **[*Editor's note: Subsection (5.5)(a)(V)(F) is effective January 1, 2026.*]** Not reverse or alter a determination of medical necessity made pursuant to this subsection (5.5), including downgrading or bundling the coding of a claim, through a review or audit of a claim, except in cases of fraud or where the covered person did not have a valid policy when the service was provided.

(VI) **[*Editor's note: Subsection (5.5)(a)(VI) is effective January 1, 2026.*]** If a health benefit plan provides any benefits for a mental health condition or substance use disorder in any classification of benefits, it must provide meaningful benefits for that mental health condition or substance use disorder in every classification in which medical or surgical benefits are provided. Whether the benefits provided are meaningful benefits is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the health benefit plan provides benefits for one or more medical conditions or surgical procedures. A health benefit plan does not provide meaningful benefits unless it provides benefits for a core treatment for that condition or disorder in each classification in which the health benefit plan provides benefits for a core treatment for one or more medical conditions or surgical procedures. A core treatment for a condition or disorder is a standard treatment or course of treatment, therapy, service, or intervention indicated by generally accepted standards of behavioral, mental health, and substance use disorder care. If there is no core treatment for a covered mental health condition or substance use disorder with respect to a classification, the health benefit plan is not required to provide benefits for a core treatment for such condition or disorder in that classification, but must provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(b) **[*Editor's note: This version of subsection (5.5)(b) is effective until January 1, 2026.*]** The commissioner may adopt rules as necessary to ensure that this subsection (5.5) is implemented and administered in compliance with federal law and shall adopt rules to establish reasonable time periods for visits with a provider for treatment of a behavioral, mental health, or substance use disorder after an initial visit with a provider.

(b) **[*Editor's note: This version of subsection (5.5)(b) is effective January 1, 2026.*]** The commissioner:

(I) May adopt rules as necessary to ensure that this subsection (5.5) is implemented and compliantly administered;

(II) May adopt rules to establish carrier utilization review compliance in accordance with subsection (5.5)(a)(I.5) of this section;

(III) May adopt rules as necessary to specify data testing requirements to determine plan design and application of parity compliance for nonquantitative treatment limitations using outcomes data;

(IV) May adopt rules to set standard definitions for coverage requirements, including processes, strategies, evidentiary standards, and other factors;

(V) May adopt rules to establish specific timelines for carrier compliance to provide comparative analysis information to the division for review, including the effect of a carrier's lack of sufficient comparative analyses to demonstrate compliance; and

(VI) May adopt rules to establish reasonable time periods and documentation of such time periods for visits with a provider for treatment of a behavioral, mental health, or substance use disorder after an initial visit with a provider.

(c) A carrier offering a managed care plan that does not cover services provided by an out-of-network provider may provide that the benefits required by this subsection (5.5) are covered benefits if the services are rendered by a provider who is designated by and affiliated with the managed care plan only if the same requirement applies for services for a physical illness.

(c.3) **[*Editor's note: Subsection (5.5)(c.3) is effective January 1, 2026.*]** This subsection (5.5) applies to any individual, entity, or contracting provider that performs utilization review functions on behalf of a health benefit plan.

(c.5) **[*Editor's note: Subsection (5.5)(c.5) is effective January 1, 2026.*]** A carrier offering a health benefit plan shall not adopt, impose, or enforce terms in its policies or provider agreement, in writing or in operation, that undermine, alter, or conflict with the requirements of this subsection (5.5).

(d) **[*Editor's note: This version of subsection (5.5)(d) is effective until January 1, 2026.*]** As used in this subsection (5.5), "behavioral, mental health, and substance use disorder":

(I) Means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

(A) The International Statistical Classification of Diseases and Related Health Problems;

(B) The Diagnostic and Statistical Manual of Mental Disorders; or

(C) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; and

(II) Includes autism spectrum disorders, as defined in subsection (1.4)(a)(III) of this section.

(d) **[*Editor's note: This version of subsection (5.5)(d) is effective January 1, 2026.*]** As used in this subsection (5.5):

(I) "Appropriate nonparticipating provider" means a provider who is accessible and has the training and experience necessary to provide age-appropriate, medically necessary treatment of a behavioral, mental health, or substance use disorder.

(II) "Behavioral, mental health, and substance use disorder":

(A) Means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of the "International Statistical Classification of Diseases and Related Health Problems", the "Diagnostic and Statistical Manual of Mental Disorders", or the "Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood"; and

(B) Includes autism spectrum disorders, as defined in subsection (1.4)(a)(III) of this section.

(III) "Generally accepted standards of behavioral, mental health, and substance use disorder care" means standards of care and clinical practice that are generally recognized by health-care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical social work, psychiatric nursing, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of behavioral, mental health, and substance use disorder care include peer-reviewed scientific studies and medical literature; clinical practice guidelines and recommendations of nonprofit

health-care provider professional associations, specialty societies, and federal government agencies; and drug labeling approved by the FDA.

(IV) "Medically necessary treatment" means a service or product addressing the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating a behavioral, mental health, or substance use disorder or its symptoms, including minimizing the progression of the disorder, in a manner that is:

(A) In accordance with the generally accepted standards of behavioral, mental health, and substance use disorder care;

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(C) Not primarily for the economic benefit of the insurer or purchaser or for the convenience of the covered person, treating physician, or other health-care provider.

(V) "Utilization review" means prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying requests by health-care providers, covered persons, or their authorized representatives for coverage, based in whole or in part on medical necessity, or for out-of-network services required pursuant to subsection (5.5)(a)(V)(D) of this section.

(VI) "Utilization review criteria" means an evaluation of the necessity, appropriateness, and efficiency of the use of health-care services, procedures, and facilities, including out-of-network services required pursuant to subsection (5.5)(a)(V)(D) of this section. "Utilization review criteria" does not include an independent medical examination provided for in any policy.

(e) **[*Editor's note: Subsection (5.5)(e) is effective January 1, 2026.*]**

(I) This subsection (5.5) does not expand coverage requirements beyond the state essential health benefits benchmark plan as required pursuant to 45 CFR 156.111.

(II) If an exclusion for behavioral health, mental health, or substance use disorder services is not permitted under the MHPAEA, coverage for these services must meet the requirements of this subsection (5.5).

(6) **Dependent children.** (a) No entity subject to the provisions of this article or section 607 (1) of the federal "Employee Retirement Income Security Act of 1974", as amended, shall refuse to accept and honor an otherwise valid claim for a covered benefit that is filed by either parent of a covered child, or by the state department of human services in the case of an assignment under section 26-13-106, C.R.S., who submits valid copies of medical bills. A claim submitted by a custodial parent who is not the insured under a policy issued by an entity subject to the provisions of this article or section 607 (1) of the federal "Employee Retirement Income Security Act of 1974", as amended, shall be deemed a valid assignment of benefits for payment to the health-care provider.

(b) An entity described in subsection (6)(a) of this section must not refuse to provide coverage for a dependent child under the health plan of the child's parent for the sole reason that:

(I) The child does not live in the home of the parent applying for the policy; or

(II) The child does not live in the insurer's service area, notwithstanding any other provision of law restricting enrollment to the persons who reside in an insurer's service area; or

(III) The child's parents were not married at the time of his or her birth; or

(IV) The child is not claimed as a dependent on the child's parent's federal or state income tax return.

(c) When a dependent child is enrolled in a health insurance plan of a parent with whom the child resides less than fifty percent of the time, the entity described in paragraph (a) of this subsection (6) shall:

(I) Provide to the dependent child's parent with whom the child resides the majority of the time information that is necessary for the dependent child to obtain medical benefits and services;

(II) Allow the parent described in subparagraph (I) of this paragraph (c), the health-care provider with such parent's approval, or the state to submit claims for covered services without the approval of the other parent;

(III) Make payments directly to the parent described in subparagraph (I) of this paragraph (c), the health-care provider, or the state medical assistance agency on claims submitted pursuant to subparagraph (II) of this paragraph (c).

(d) Whenever a parent of a dependent child with whom the child resides less than fifty percent of the time is subject to a court or an administrative order to provide health-care coverage for the dependent child, and such parent is eligible for family health-care coverage through the parent's employment, the entity described in paragraph (a) of this subsection (6) shall:

(I) Permit such parent to enroll the dependent child under the family coverage plan, regardless of any enrollment season restriction;

(II) Enroll the dependent child upon application for enrollment by the parent with whom the child resides the majority of the time, the state medical assistance agency, or the state child support enforcement agency or a delegate child support enforcement unit if the parent with whom the child resides less than fifty percent of the time is enrolled in a family coverage plan but fails to enroll the dependent child, regardless of any enrollment restrictions;

(III) Not cancel or revoke enrollment of the dependent child, or eliminate coverage for the dependent child, unless the insurer is provided with satisfactory written proof that:

(A) The court or administrative order for health-care coverage is no longer in effect; or

(B) The child is or will be enrolled in a comparable plan through another insurer, which enrollment takes effect no later than the effective date of the cancellation or revocation of enrollment or the elimination of coverage.

(e) An entity described in paragraph (a) of this subsection (6) shall not impose on the state medical assistance agency that is assigned the right to recover medical costs on behalf of a medical assistance recipient any requirement that is not imposed on or applicable to other agents or assignees.

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

(b) An entity described in paragraph (a) of subsection (6) of this section shall not deny or restrict coverage to an adopted child of an enrollee, policyholder, or subscriber or a child placed for adoption with an enrollee, policyholder, or subscriber on the basis of a preexisting condition if the child would otherwise be eligible for enrollment or coverage and the adoption or

placement occurs while the adoptive parent or parent with whom the child is placed is enrolled in the plan.

(c) For the purposes of this subsection (6.5), unless the context otherwise requires:

(I) "Child" means a person who has not attained eighteen years of age.

(II) "Placed for adoption" means circumstances under which a person assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates at the time such legal obligation terminates.

(6.7) **Medical assistance recipients - denial of coverage - liability to state.** (a) No entity subject to the provisions of this article, article 8 of this title, or section 607 (1) of the federal "Employee Retirement Income Security Act of 1974", as amended, shall refuse to enroll a person for the sole reason that the person is a medical assistance recipient for whom coverage is sought pursuant to section 25.5-4-210, C.R.S., or refuse to accept and honor an otherwise valid claim for a covered benefit which is filed in the case of an assignment under the provisions of articles 4, 5, and 6 of title 25.5, C.R.S.

(b) An entity subject to this subsection (6.7) that is liable as a third party for the medical costs of a medical assistance recipient or that recovers or may recover medical costs from a third party who is liable to a medical assistance recipient for medical costs is liable to the state pursuant to section 25.5-4-301 (4), C.R.S.

(c) The state is deemed to have acquired the rights as an assignee of the medical assistance recipient to any payment by a third party for medical costs.

(7) Repealed.

(8) **Availability of hospice care coverage.** (a) As used in this subsection (8), unless the context otherwise requires:

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

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

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

(c) The insurer or entity may adopt standards and criteria for eligibility to be applied to home health services programs and hospice care programs consistent with standards established in rules and regulations of the department of public health and environment.

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

(9) Repealed.

(10) **Prostate cancer screening.** (a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health-care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health-care coverage offered to residents of this state, shall provide coverage for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles. Such coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. Such benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. This coverage shall be provided according to the following guidelines:

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

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

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

(B) Digital rectal examination.

(III) At least one screening per year shall be covered for any man fifty years of age or older.

(IV) At least one screening per year shall be covered for any man from forty to fifty years of age who is at increased risk of developing prostate cancer as determined by the man's physician for an entity subject to part 2 or 3 of this article, or as determined by a participating physician for an entity subject to part 4 of this article.

(b) The requirements of this subsection (10) shall apply to all individual sickness and accident insurance policies and health-care service or indemnity contracts issued on or after January 1, 1996, and to all group accident and sickness policies and group health-care service or indemnity contracts issued, renewed, or reinstated on or after January 1, 1996.

(c) For purposes of this subsection (10), "sickness and accident insurance policy" does not include short-term, accident, fixed indemnity, specified disease policies or disability income contracts, and limited benefit or credit disability insurance, or such other insurance as defined in section 10-18-101 (3) or by the commissioner. The term also does not include insurance arising out of the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S., or other similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance.

(d) The health-care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits provided pursuant to this subsection (10) shall be

covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(11) Repealed.

(12) **Hospitalization and general anesthesia for dental procedures for dependent children.** (a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to part 2 of this article and all individual and group health-care service or indemnity contracts issued by an entity subject to part 3 or 4 of this article, except supplemental policies that cover a specific disease or other limited benefit, must 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 (17), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

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

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

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

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

(b) A carrier may:

(I) Require prior authorization for general anesthesia and outpatient surgical facilities or hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions; and

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

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

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

(13) **Diabetes.** (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).

(14) **Prosthetic devices.** (a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, 1395l, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100, as applicable to this subsection (14).

(b) As used in this subsection (14), "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(c) A health benefit plan may require prior authorization for prosthetic devices in the same manner that prior authorization is required for any other covered benefit.

(d) (I) Except as provided in subsection (14)(d)(II) of this section, covered benefits are limited to the most appropriate prosthetic device models that adequately meet the medical needs of the covered person as determined by the covered person's treating physician.

(II) With respect to a covered person, covered benefits include an additional prosthetic device or devices if the treating physician determines that the additional prosthetic device or devices are necessary to enable the covered person to engage in physical and recreational activities, including running, bicycling, swimming, climbing, skiing, snowboarding, and team and individual sports.

(III) The division shall submit to the federal department of health and human services:

(A) A determination as to whether the benefit specified in subsection (14)(d)(II) of this section is in addition to an essential health benefit that requires the state to defray the cost pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); and

(B) A request that the federal department confirm the division's determination within sixty days after receiving the division's submission.

(IV) Subsection (14)(d)(II) of this section applies to, and the division shall implement the requirements for, large employer policies and contracts issued or renewed on or after January 1, 2025. Subsection (14)(d)(II) of this section applies to, and the division shall implement the requirements for, individual and small group policies and contracts issued on or after January 1, 2025, if:

(A) The division receives confirmation or any other notification from the federal department of health and human services that the coverage specified in subsection (14)(d)(II) of this section does not constitute an additional benefit that requires the state to defray the cost pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); or

(B) The federal department of health and human services fails to respond to the request submitted by the division pursuant to subsection (14)(d)(III) of this section within three hundred sixty-five days after submission of the request, in which case the division shall consider the federal department's unreasonable delay a confirmation that the coverage specified in subsection (14)(d)(II) of this section does not require the state to defray the cost pursuant to 42 U.S.C. sec. 18031 (d)(3)(B).

(e) Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.

(f) A carrier may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to this subsection (14) shall be covered benefits only if the prosthetic

devices are provided by a vendor and prosthetic services are rendered by a provider who contracts with or is designated by the carrier, to the extent that a carrier provides in-network and out-of-network services, the coverage for the prosthetic device shall be offered no less extensively.

(15) and (16) Repealed.

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

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

(c) For purposes of this subsection (17), "sickness and accident insurance policy" does not include short-term, accident, fixed indemnity, specified disease policies or disability income contracts, and limited benefit or credit disability insurance, or such other insurance as described in section 10-18-101 (3) or by the commissioner. The term also does not include insurance arising out of the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S., or other similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in a liability insurance policy or equivalent self-insurance.

(d) The health-care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits provided pursuant to this subsection (17) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(18) **Prevention health-care services - rules - definitions.** (a) (I) The following policies and contracts that are issued or renewed in this state must provide coverage for the total cost of the preventive health-care services specified in subsections (18)(b), (18)(b.3), and (18)(b.7) of this section:

(A) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to part 2 of this article;

(B) All individual and group health-care service or indemnity contracts issued by an entity subject to part 3 or 4 of this article; and

(C) Any other individual or group health-care coverage offered to residents of this state.

(II) Repealed.

(III) (A) Except as provided in subsection (18)(a)(III)(B) of this section, coverage required by this subsection (18) is not subject to policy deductibles, copayments, or coinsurance.

(B) For purposes of grandfathered health benefit plans, coverage required by this subsection (18) is not subject to policy deductibles or coinsurance. Copayments may apply as required by the grandfathered health benefit plan.

(b) The coverage required by this subsection (18) must include coverage for the preventive health-care services listed in subsections (18)(b)(I) to (18)(b)(XI) of this section in accordance with the A or B recommendations of the task force, recommendations established by the ACIP, or preventive care and screening as provided for in the comprehensive guidelines. If the A or B recommendations of the task force, the ACIP, or the comprehensive guidelines are repealed, modified, or otherwise no longer in effect, the commissioner may adopt rules to require compliance with the guidelines or recommendations that were in effect in January 2025, or that comply with the recommendations of the nurse-physician advisory task force for Colorado health care created in section 12-30-105 and developed in compliance with the requirements set forth in section 12-30-105 (5), that apply to coverage of the following preventive health-care services:

(I) Unhealthy alcohol use screening for adults, depression screening for adolescents and adults, and perinatal maternal counseling for persons at risk. The services specified in this section may be provided by a primary care provider, behavioral health-care provider, as defined in section 25-1.5-502 (1.3), or mental health professional licensed or certified pursuant to article 245 of title 12.

(II) Cervical cancer screening;

(III) Repealed.

(IV) Cholesterol screening for lipid disorders;

(V) (A) Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps.

(B) In addition to covered persons eligible for colorectal cancer screening coverage in accordance with the A or B recommendations of the task force, colorectal cancer screening coverage required by this subparagraph (V) shall also be provided to covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition, such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

(VI) Child health supervision services and childhood immunizations pursuant to the schedule established by the ACIP;

(VII) Influenza vaccinations pursuant to the schedule established by the ACIP;

(VIII) Pneumococcal vaccinations pursuant to the schedule established by the ACIP;

(IX) Tobacco use screening of adults and tobacco cessation interventions by primary care providers; and

(X) (A) Any other preventive services included in the A or B recommendation of the task force or required by federal law; any other recommendations established by the ACIP; or any other preventive care and screening, as provided for in the comprehensive guidelines.

(B) This subsection (18)(b)(X) does not apply to grandfathered health benefit plans.

(XI) (A) Counseling, prevention, and screening for a sexually transmitted infection, as defined in section 25-4-402 (10); except that the coverage under this subsection (18)(b)(XI) must be provided to all covered persons regardless of the covered person's gender.

(B) The division shall submit to the federal department of health and human services its determination as to whether the benefit specified in this subsection (18)(b)(XI) is in addition to essential health benefits and would be subject to defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B) and a request that the federal department confirm the division's determination within sixty days after receipt of the division's request and submission of its determination.

(C) This subsection (18)(b)(XI) applies to large employer policies or contracts issued or renewed on or after January 1, 2022, and to individual and small group policies and contracts issued on or after January 1, 2023, and the division shall implement the requirements of this subsection (18)(b)(XI) if the division receives confirmation from the federal department of health and human services that the coverage specified in this subsection (18)(b)(XI) does not constitute an additional benefit that requires defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); the federal department of health and human services has otherwise informed the division that the coverage does not require state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); or more than three hundred sixty-five days have passed since the division submitted its determination and request for confirmation that the coverage specified in this subsection (18)(b)(XI) is not an additional benefit that requires state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B), and the federal department of health and human services has failed to respond to the request within that period, in which case the division shall consider the federal department's unreasonable delay a preclusion from requiring defrayal by the state.

(b.3) For health benefit plans issued or renewed on or after January 1, 2025, if counseling, prevention, and screening for a sexually transmitted infection, as required in subsection (18)(b)(XI) of this section, are covered services, the health benefit plan must provide the coverage without cost sharing, regardless of the covered person's gender, and the coverage must include, consistent with task force requirements, coverage for HIV prevention drugs and services necessary for initiation and continued use of HIV prevention drugs, including office visits, testing, vaccinations, and monitoring services.

(b.5) (I) The coverage required pursuant to this subsection (18) must include a preventive breast cancer screening study that is within appropriate use guidelines as determined by the American College of Radiology, the National Comprehensive Cancer Network, or their successor entities.

(II) Notwithstanding other coverage provisions of subsection (18)(b.5)(I) of this section, a policy or contract subject to this subsection (18) must cover an annual breast cancer screening using the appropriate noninvasive imaging modality or combination of modalities recognized by the American College of Radiology or the National Comprehensive Cancer Network, or their successor entities, for all individuals possessing at least one risk factor for breast cancer, including:

(A) A family history of breast cancer;

(B) Being forty years of age or older; or

(C) An increased lifetime risk of breast cancer determined by a risk factor model, such as Tyrer-Cuzick, BRCAPRO, or Gail, or by other clinically appropriate risk assessment models.

(III) The coverage required pursuant to this subsection (18)(b.5) must include:

(A) A medically necessary and appropriate diagnostic examination of the breast that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or used to evaluate an abnormality detected by another means of examination; and

(B) A medically necessary and appropriate supplemental examination of the breast that is used to screen for breast cancer when there is no abnormality seen or suspected and that is based on personal or family medical history or additional factors that increase the individual's risk of breast cancer, including heterogeneously or extremely dense breasts.

(IV) The coverage required pursuant to this subsection (18)(b.5) must cover the following services, without cost-sharing requirements, including deductibles, coinsurance, copayments, or any maximum limitation on the application of such deductibles, coinsurance, or copayments or similar out-of-pocket expenses:

(A) Breast cancer screening studies;

(B) Diagnostic examinations of the breast that are medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network guidelines, including such an examination using contrast-enhanced mammography, diagnostic mammography, breast magnetic resonance imaging, breast ultrasound, or molecular breast imaging; and

(C) Supplemental examinations of the breast that are medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network guidelines, including such an examination using contrast-enhanced mammography, breast magnetic resonance imaging, breast ultrasound, or molecular breast imaging.

(V) If application of this subsection (18) would make a covered person's health savings account contributions ineligible under section 223 of the federal "Internal Revenue Code of 1986", 26 U.S.C. sec. 223, this subsection (18) applies to the deductible applicable to the covered person's health benefit plan after the covered person has satisfied the minimum deductible amount under 26 U.S.C. sec. 223; except that, with respect to items or services that are preventive care pursuant to 26 U.S.C. sec. 223 (c)(2)(C), this subsection (18) applies, regardless of whether the minimum deductible under 26 U.S.C. sec. 223 has been satisfied.

(b.7) (I) For large employer policies and contracts issued or renewed on or after January 1, 2022, and for individual and small group policies and contracts issued or renewed on or after January 1, 2023, the coverage required by this subsection (18) must include an annual mental health wellness examination of up to sixty minutes that is performed by a qualified mental health-care provider. The coverage for an annual mental health wellness examination must be no less extensive than the coverage provided for a physical examination and must comply with the requirements of the MHPAEA.

(II) The division shall conduct an actuarial study to determine the effect, if any, the coverage required by this subsection (18)(b.7) has on premiums.

(III) Within one hundred twenty days after July 6, 2021, the division shall submit to the federal department of health and human services:

(A) Its determination as to whether the coverage specified in this subsection (18)(b.7) is in addition to essential health benefits and would be subject to defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); and

(B) A request that the federal department confirm the division's determination within sixty days after receipt of the division's request and submission of its determination.

(IV) This subsection (18)(b.7) applies to large employer policies or contracts issued or renewed on or after January 1, 2022, and to individual and small group policies and contracts issued on or after January 1, 2023, and the division shall implement the requirements of this subsection (18)(b.7), if:

(A) The division receives confirmation from the federal department of health and human services that the coverage specified in this subsection (18)(b.7) does not constitute an additional benefit that requires defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B);

(B) The federal department of health and human services has informed the division that the coverage does not require state defrayal; or

(C) More than three hundred sixty-five days have passed since the division submitted its determination and request for confirmation that the coverage specified in this subsection (18)(b.7) is not an additional benefit that requires state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B), and the federal department of health and human services has failed to respond to the request within that period, in which case the division shall consider the federal department's unreasonable delay a preclusion from requiring defrayal by the state.

(c) As used in this subsection (18):

(I) "ACIP" means the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services, or any successor entity.

(II) "A recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health-care service because the task force found there is a high certainty that the net benefit of the preventive health-care service is substantial.

(III) "B recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health-care service because the task force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

(III.5) "Breast cancer screening study" and "breast imaging" mean:

(A) A mammogram, with or without a clinical exam, for individuals at average risk;

(B) A mammogram or other noninvasive imaging modality or modalities, as recommended by the medical provider; or

(C) A mammogram, with or without a clinical exam, and medically recommended subsequent noninvasive imaging modality or modalities that fall within appropriate use guidelines as determined by the American College of Radiology, the National Comprehensive Cancer Network, or their successor entities, for the early detection of breast cancer for individuals at average risk who have an incomplete mammogram result or for individuals at high risk.

(III.6) "Comprehensive guidelines" means the following comprehensive guidelines supported by the health resources and services administration in the United States department of health and human services:

(A) Preventive care and screening for women; and

(B) Evidence-informed preventive care and screening for infants, children, and adolescents.

(III.7) "Mental health wellness examination" means an examination that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include:

(A) Observation; a behavioral health screening; education and consultation on healthy lifestyle changes; referrals to ongoing treatment, mental health services, and other necessary supports; and discussion of potential options for medication; and

(B) Age-appropriate screenings or observations to understand a covered person's mental health history, personal history, and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews, and questions.

(III.9) "Qualified mental health-care provider" means:

(A) A physician licensed to practice medicine pursuant to article 240 of title 12 who has specific board certification or training in psychiatry or other mental or behavioral health-care areas;

(B) A physician assistant licensed pursuant to article 240 of title 12 who has training in psychiatry or mental health;

(C) A psychologist licensed pursuant to part 3 of article 245 of title 12;

(D) A clinical social worker licensed pursuant to part 4 of article 245 of title 12;

(E) A marriage and family therapist licensed pursuant to part 5 of article 245 of title 12;

(F) A professional counselor licensed pursuant to part 6 of article 245 of title 12;

(G) An addiction counselor licensed pursuant to part 8 of article 245 of title 12; or

(H) An advanced practice registered nurse, as defined in section 12-255-104 (1), with specific training in psychiatric nursing.

(IV) "Task force" means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal department of health and human services.

(d) The health-care service plan issued by an entity subject to part 4 of this article may provide that the benefits provided pursuant to this subsection (18) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(e) (I) A carrier shall reimburse a pharmacist employed by an in-network pharmacy for prescribing and dispensing HIV prevention drugs to a covered person. A carrier shall provide a pharmacist who prescribes and dispenses HIV prevention drugs to a covered person pursuant to section 12-280-125.7 an adequate consultative fee or, if medical billing is not available, an enhanced dispensing fee, that is equivalent or that is provided to a physician or advanced practice registered nurse.

(II) This subsection (18)(e) does not apply to an integrated health-care delivery system that dispenses a majority of prescription drugs through integrated pharmacies.

(f) The commissioner may adopt rules as necessary to implement and enforce this subsection (18), including rules that require coverage of additional preventive health-care services not listed in subsections (18)(b)(I) to (18)(b)(XI) of this section as recommended by the task force, ACIP, comprehensive guidelines, or nurse-physician advisory task force for Colorado health care.

(g) A health insurance policy that qualifies for a health savings account pursuant to 26 U.S.C. sec. 223 is exempt from subsections (18)(b) and (18)(f) of this section to the extent the exemption is necessary to allow the policy to qualify for a health savings account pursuant to the requirements in the federal law.

(18.1) **Contraception.** (a) Policies or contracts described in subsection (18)(a)(I) of this section issued or renewed in this state must provide coverage for the total cost of contraception, as defined in section 2-4-401 (1.5).

(b) The coverage required by this subsection (18.1) is not subject to policy deductibles, copayments, or coinsurance.

(c) This subsection (18.1) does not apply to grandfathered health benefit plans.

(d) (I) The division shall submit to the federal department of health and human services:

(A) Its determination as to whether the benefit specified in this subsection (18.1) is in addition to essential health benefits and would be subject to defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); and

(B) A request that the federal department confirm the division's determination within sixty days after receipt of the division's request and submission of its determination.

(II) This subsection (18.1) applies to large employer policies or contracts issued or renewed on or after January 1, 2022, and to individual and small group policies and contracts issued on or after January 1, 2023, and the division shall implement the requirements of this subsection (18.1), if:

(A) The division receives confirmation from the federal department of health and human services that the coverage specified in this subsection (18.1) does not constitute an additional benefit that requires defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B);

(B) The federal department of health and human services has otherwise informed the division that the coverage does not require state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); or

(C) More than three hundred sixty-five days have passed since the division submitted its determination and request for confirmation that the coverage specified in this subsection (18.1) is not an additional benefit that requires state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B), and the federal department of health and human services has failed to respond to the request within that period, in which case the division shall consider the federal department's unreasonable delay a preclusion from requiring defrayal by the state.

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

(b) Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, must provide coverage for hearing aids for minor children who have a hearing loss that has been verified by a physician licensed pursuant to article 240 of title 12 and by an audiologist licensed pursuant to article 210 of title 12. The hearing aids must be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage must include the purchase of the following:

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

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

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

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

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

(20) **Clinical trials and studies.** (a) All individual and group health benefit plans shall provide coverage for routine patient care costs that a policy or certificate holder, or his or her dependent, receives during a clinical trial if:

(I) The covered person's treating physician, who is providing covered health-care services to the person under the health benefit plan contract, recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the covered person;

(II) The clinical trial or study is approved under the September 19, 2000, medicare national coverage decision regarding clinical trials, as amended;

(III) The patient care is provided by a certified, registered, or licensed health-care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;

(IV) Prior to participation in a clinical trial or study, the covered person has signed a statement of consent indicating that the covered person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participation in the clinical trial or study, the coverage provided by an individual or group health benefit plan will be consistent with the coverage provided in the covered person's health benefit plan, and all out-of-network rates will apply; and

(V) The covered person suffers from a condition that is disabling, progressive, or life-threatening.

(b) The coverage required pursuant to paragraph (a) of this subsection (20) does not include:

(I) Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;

(II) Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;

(III) Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;

(IV) An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;

(V) Costs for the management of research relating to the clinical trial or study; or

(VI) Health-care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the covered person's health plan.

(c) Nothing in this subsection (20) shall:

(I) Preclude a carrier from asserting the right to seek reimbursement from the entity conducting the clinical trial or study for expenses arising from complications caused by a drug or device used in the clinical trial or study;

(II) Be interpreted to provide a private cause of action against a carrier for damages arising as a result of compliance with this section.

(d) For the purposes of this section:

(I) "Clinical trial" means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

(II) "Routine patient care cost" means all items and services that are a benefit under a health coverage plan that would be covered if the covered person were not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

(21) **Oral anticancer medication.** (a) Any health benefit plan that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medication that has been approved by the FDA and is used to kill or slow the growth of cancerous cells. The orally administered medication shall be provided at a cost to the covered person not to exceed the coinsurance percentage or the copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose. A medication provided pursuant to this subsection (21) shall be prescribed only upon a finding that it is medically necessary by the treating physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not primarily for the convenience of the patient, physician, or other health-care provider. This subsection (21) does not require the use of orally administered medications as a replacement for other cancer medications. Nothing in this subsection (21) prohibits coverage for oral generic medications in a health benefit plan. Nothing in this subsection (21) prohibits a carrier from applying an appropriate formulary or other clinical management to any medication described in this subsection (21). For the purposes of this subsection (21), the treating physician for a patient covered under a health maintenance organization's health benefit plan shall be a physician who is designated by and affiliated with the health maintenance organization.

(b) A carrier shall not achieve compliance with this subsection (21) by imposing an increase in patient out-of-pocket costs with respect to anticancer medications used to kill or slow the growth of cancerous cells covered under a policy beyond the modifications permitted pursuant to section 10-16-105.1 (5).

(22) **Prescription eye drop refill coverage.** (a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides coverage for prescription eye drops shall provide coverage for:

(I) A renewal of prescription eye drops if:

(A) The renewal is requested by the insured at least twenty-one days for a thirty-day supply of eye drops, forty-two days for a sixty-day supply of eye drops, or sixty-three days for a ninety-day supply of eye drops, from the later of the date that the original prescription was distributed to the insured or the date that the last renewal of the prescription was distributed to the insured; and

(B) The original prescription states that additional quantities are needed and the renewal requested by the insured does not exceed the number of additional quantities needed; and

(II) One additional bottle of prescription eye drops if:

(A) A bottle is requested by the insured or the health-care provider at the time the original prescription is filled; and

(B) The original prescription states that one additional bottle is needed by the insured for use in a day care center, school, or adult day program. The additional bottle is limited to one bottle every three months.

(b) The prescription eye drop benefits covered under this subsection (22) are subject to the same annual deductibles, copayment, or coinsurance established for all other prescription drug benefits under the health benefit plan.

(23) **Infertility diagnosis and treatment - fertility preservation services.** (a) Except as provided in subsection (23)(e) of this section and subject to subsection (23)(f) of this section, all individual and group health benefit plans issued or renewed in this state shall provide coverage for the diagnosis of and treatment for infertility and standard fertility preservation services.

(b) The coverage required by this subsection (23) includes three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the ASRM, using single embryo transfer when recommended and medically appropriate.

(c) The health benefit plan shall not impose:

(I) Any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from the exclusions, limitations, or other restrictions imposed on any other prescription medications covered under the health benefit plan; or

(II) Deductibles, copayments, coinsurance, benefit maximums, waiting periods, or other limitations on coverage for the diagnosis of and treatment for infertility and standard fertility preservation services, except as otherwise specified in this subsection (23), that are different from deductibles, copayments, coinsurance, benefit maximums, waiting periods, or other limitations imposed on benefits for services covered under the health benefit plan that are not related to infertility.

(d) The commissioner shall adopt rules consistent with and as are necessary to implement this subsection (23).

(e) A religious employer may request and a carrier subject to this subsection (23) shall grant an exclusion from the coverage required under this subsection (23) in a health benefit plan if the required coverage conflicts with the religious organization's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection (23)(e) shall

provide its employees reasonable and timely notice of the exclusion of the coverage described in this subsection (23) from the health benefit plan the religious employer offers to its employees.

(f) (I) This subsection (23) applies to, and the division shall implement the requirements of this subsection (23) for, large employer health benefit plans issued or renewed in this state on or after January 1, 2023.

(II) This subsection (23) applies to, and the division shall implement the requirements of this subsection (23) for, individual and small group health benefit plans issued or renewed in this state twelve months after the federal department of health and human services determines that the coverage specified in this subsection (23) does not constitute an additional benefit that requires defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B).

(g) As used in this subsection (23):

(I) "ACOG" means the American College of Obstetricians and Gynecologists or its successor organization.

(II) "ASCO" means the American Society of Clinical Oncology or its successor organization.

(III) "ASRM" means the American Society for Reproductive Medicine or its successor organization.

(IV) "Diagnosis of and treatment for infertility" means the procedures and medications recommended by a licensed physician that are consistent with established, published, or approved medical practices or professional guidelines from ACOG or ASRM for diagnosing and treating infertility.

(V) "Failure to impregnate or conceive" means the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse or therapeutic donor insemination for a woman under the age of thirty-five, or after six months of regular, unprotected sexual intercourse or therapeutic donor insemination for a woman thirty-five years of age or older. Conception resulting in a miscarriage does not restart the twelve-month or six-month clock to qualify as having infertility.

(VI) "Infertility" means a disease or condition characterized by:

(A) The failure to impregnate or conceive;

(B) A person's inability to reproduce either as an individual or with the person's partner; or

(C) A licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

(VII) "Licensed physician" means a person licensed by the Colorado medical board pursuant to article 240 of title 12 to practice medicine in this state.

(VIII) "Standard fertility preservation services" means procedures and services that are consistent with established medical practices or professional guidelines published by ASRM or ASCO for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

(24) **Living organ donation - rules - definitions.** (a) (I) All individual and group health benefit plans issued or renewed in this state on and after January 1, 2022, shall provide coverage for health-care services related to living organ donation for a covered person who is a living organ donor.

(II) The health benefit plan shall not impose any deductibles, copayments, coinsurance, benefit maximums, waiting periods, or other limitations on coverage for health-care services related to living organ donation.

(III) The commissioner shall adopt rules consistent with and as are necessary to implement this subsection (24).

(b) As used in this subsection (24):

(I) "Health-care services related to living organ donation" means an organ donation recovery operation and all services required before and after the operation.

(II) "Living organ donor" means a living individual who has donated all or part of an organ.

(III) "Organ donation recovery operation" means a procedure to recover an organ from a living organ donor.

(25) **Nonpharmacological alternative treatment to opioids.** (a) A health benefit plan issued or renewed on or after January 1, 2023, must align cost-sharing amounts for nonpharmacological treatment for a patient with a pain diagnosis where an opioid might be prescribed, which must include a cost-sharing amount for each visit not to exceed the cost-sharing amount for a primary care visit for nonpreventive services for a minimum of six physical therapy visits, six occupational therapy visits, six chiropractic visits, and six acupuncture visits.

(b) At the time of a covered person's initial visit for treatment, a physical therapist, occupational therapist, chiropractor, or acupuncturist shall notify the covered person's carrier that the covered person has started treatment with the provider.

(c) (I) The division shall submit to the federal department of health and human services:

(A) Its determination as to whether the benefit specified in this subsection (25) is in addition to essential health benefits and would be subject to defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); and

(B) A request that the federal department confirm the division's determination within sixty days after receipt of the division's request and submission of its determination.

(II) This subsection (25) applies to large employer policies or contracts issued or renewed on or after January 1, 2022, and to individual and small group policies and contracts issued on or after January 1, 2023, and the division shall implement the requirements of this subsection (25), if:

(A) The division receives confirmation from the federal department of health and human services that the coverage specified in this subsection (25) does not constitute an additional benefit that requires defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B);

(B) The federal department of health and human services has otherwise informed the division that the coverage does not require state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); or

(C) More than three hundred sixty-five days have passed since the division submitted its determination and request for confirmation that the coverage specified in this subsection (25) is not an additional benefit that requires state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B), and the federal department of health and human services has failed to respond to the request within that period, in which case the division shall consider the federal department's unreasonable delay a preclusion from requiring defrayal by the state.

(d) The division shall conduct an actuarial study to determine the effect, if any, the cost-sharing benefit required by this subsection (25) has on premiums.

(26) **Abortion care - rules - definition.**

(a) **[*Editor's note: This version of subsection (26)(a) is effective until January 1, 2026.*]** Except as provided in subsections (26)(d) and (26)(g) of this section and subject to the provisions of subsections (26)(e) and (26)(f) of this section, all individual and group health benefit plans issued or renewed in this state shall provide coverage for the total cost of abortion care.

(a) **[*Editor's note: This version of subsection (26)(a) is effective January 1, 2026.*]** Except as provided in subsections (26)(d) and (26)(g) of this section and subject to subsection (26)(e) of this section, all individual and group health benefit plans issued or renewed in this state shall provide coverage for the total cost of abortion care.

(b) The coverage required pursuant to this subsection (26) is not subject to policy deductibles, copayments, or coinsurance; except that copayments may apply as required by a grandfathered health benefit plan.

(c) The commissioner shall adopt rules consistent with and as are necessary to implement this subsection (26).

(d) **[*Editor's note: This version of subsection (26)(d) is effective until January 1, 2026.*]** An employer is not obligated to provide the coverage required by this subsection (26) if:

(I) Providing the coverage conflicts with the employer's sincerely held religious beliefs; or

(II) The employer is a public entity prohibited by section 50 of article V of the state constitution from using public funds to pay for induced abortions.

(d) **[*Editor's note: This version of subsection (26)(d) is effective January 1, 2026.*]** An employer is not obligated to provide the coverage required by this subsection (26) if providing the coverage conflicts with the employer's sincerely held religious beliefs.

(e) This subsection (26) applies to, and the division shall implement the requirements of this subsection (26) for, large employer health benefit plans issued or renewed in this state on or after January 1, 2025; except that copayments may apply as required by a grandfathered large employer health benefit plan.

(f) **[*Editor's note: This version of subsection (26)(f) is effective until January 1, 2026.*]** With respect to individual and small group health benefit plans:

(I) The division shall submit to the federal department of health and human services:

(A) The division's determination as to whether the benefit specified in this subsection (26) is in addition to essential health benefits and would be subject to defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); and

(B) A request that the federal department of health and human services confirm the division's determination within sixty days after receipt of the division's request for confirmation of the determination.

(II) This subsection (26) applies to, and the division shall implement the requirements of this subsection (26) for, individual and small group health benefit plans issued or renewed in this state upon the earlier of:

(A) Twelve months after the federal department of health and human services confirms that the coverage specified in this subsection (26) does not constitute an additional benefit that requires defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B);

(B) Twelve months after the federal department of health and human services otherwise informs the division that the coverage in this subsection (26) does not require state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); or

(C) The passage of more than three hundred sixty-five days since the division submitted its determination and request for confirmation pursuant to subsection (26)(f)(I) of this section, and the federal department of health and human services has failed to respond to the request within that period, in which case the division shall consider the federal department's unreasonable delay a preclusion from requiring defrayal by the state.

(f) **[*Editor's note: This version of subsection (26)(f) is effective January 1, 2026.*]** Repealed.

(g) The provisions of this subsection (26) do not apply to a high deductible health benefit plan pursuant to 26 U.S.C. sec. 223, as amended, issued or renewed in this state until an eligible insured's deductible has been met, unless allowed pursuant to federal law.

(h) As used in this subsection (26), "abortion care" has the same meaning as "abortion", as defined in section 25-6-402 (1).

(27) **Pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections (PANDAS) - rules - definitions.** (a) As used in this subsection (27), unless the context otherwise requires:

(I) "PANDAS" means pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections.

(II) "PANS" means pediatric acute-onset neuropsychiatric syndrome.

(b) (I) Except as provided in subsection (27)(g)(III) of this section and to the extent that such coverage is not in addition to benefits provided pursuant to the benchmark plan, all individual and group health benefit plans issued or renewed in this state shall provide the prophylaxis, diagnosis, and treatment of PANS and PANDAS.

(II) Coverage for PANS and PANDAS must adhere to the treatment recommendations developed by a consortium of medical professionals convened to research, identify, and publish clinical practice guidelines and evidence-based standards for the diagnosis and treatment of PANS and PANDAS.

(III) The coverage required pursuant to this subsection (27) includes treatments and therapies prescribed or ordered by the treating health-care provider, including:

(A) Antibiotics;

(B) Medication and psychological and behavioral therapies to manage neuropsychiatric symptoms;

(C) Immunomodulating medicines;

(D) Plasma exchange; and

(E) Intravenous immunoglobulin therapy.

(c) Coverage for PANS and PANDAS must include up to six immunomodulatory courses of intravenous immunoglobulin therapy for the treatment of PANS and PANDAS when the following conditions have been met:

(I) Clinically appropriate trials, which may be done concurrently, of two or more less intensive treatments:

(A) Were not effective;

(B) Were not tolerated; or

(C) Did not result in sustained improvement in symptoms, as measured by a lack of clinically meaningful improvement on a validated instrument directed at the patient's primary symptom complex; and

(II) The patient's treating health-care provider recommends the treatment or therapy or the treatment or therapy is recommended by a pediatric or, for an adolescent patient, an adult subspecialist, after consultation with the treating health-care provider.

(d) The carrier may require that the patient be clinically reevaluated at three-month intervals.

(e) For billing and diagnostic purposes, PANS and PANDAS shall be coded as autoimmune encephalitis until the American Medical Association and the federal centers for medicare and medicaid services create and assign a specific code or codes for PANS and PANDAS. After the creation of the code or codes, PANS and PANDAS may be coded as autoimmune encephalitis, PANS, or PANDAS. If PANS or PANDAS becomes known by a different common name, it may be coded under that name, and this section applies to that disorder or syndrome.

(f) The carrier shall not:

(I) Impose deductibles, copayments, coinsurance, or other limitations on coverage for PANS or PANDAS that are different from deductibles, copayments, coinsurance, or other limitations imposed on benefits for services covered under the health benefit plan that are not related to PANS or PANDAS;

(II) Deny or delay coverage for PANS or PANDAS treatments or therapies because the covered person previously received treatment or therapy, including the same or similar treatment or therapy, for PANS or PANDAS or because the covered person was diagnosed with or received treatment or therapy for the condition under a different diagnostic name, including autoimmune encephalitis;

(III) Delay timely determination of prior authorization requests for treatments or therapies or fail to expedite requests for urgent health-care services; or

(IV) Limit coverage of immunomodulating therapies for PANS or PANDAS in a manner that is inconsistent with the treatment recommendations made pursuant to subsection (27)(b)(II) of this section and shall not require a trial of therapies that treat only neuropsychiatric symptoms before authorizing coverage of immunomodulating therapies pursuant to this section.

(g) (I) The division shall submit to the federal department of health and human services:

(A) Its determination as to whether the benefit specified in this subsection (27) is in addition to essential health benefits and would be subject to defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); and

(B) A request that the federal department of health and human services confirm the division's determination within sixty days after receipt of the division's request and submission of its determination.

(II) This subsection (27) applies to, and the division shall implement the requirements of this subsection (27) for, large employer health benefit plans issued or renewed in this state on or after January 1, 2025.

(III) This subsection (27) applies to, and the division shall implement the requirements of this subsection (27) for, individual and small group health benefit plans issued or renewed in this state on or after January 1, 2026, if:

(A) The division receives confirmation from the federal department of health and human services that the coverage specified in this subsection (27) does not constitute an additional benefit that requires defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B);

(B) The federal department of health and human services has otherwise informed the division that the coverage does not require state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); or

(C) More than three hundred sixty-five days have passed since the division submitted its determination and request for confirmation that the coverage specified in this subsection (27) is not an additional benefit that requires state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B), and the federal department of health and human services has failed to respond to the request within that period, in which case the division shall consider the federal department of health and human services' unreasonable delay a preclusion from requiring defrayal by the state.

(h) The commissioner shall adopt rules consistent with and as are necessary to implement this subsection (27).

(28) **Biomarker testing - rules - definitions.** (a) All large group health benefit plans and, to the extent that such coverage is not in addition to the benefits provided pursuant to the benchmark plan, all individual and small group health benefit plans shall provide coverage for biomarker testing pursuant to this subsection (28).

(b) Coverage must include biomarker testing for diagnosis, treatment, appropriate management, and ongoing monitoring of a covered person's disease or condition to guide treatment decisions when the test is supported by medical and scientific evidence, including:

(I) Labeled indications for an FDA-approved or FDA-cleared test;

(II) Indicated tests for an FDA-approved drug;

(III) Warnings and precautions on FDA-approved drug labels;

(IV) Centers for medicare and medicaid services national coverage determinations or medicare administrative contractor local coverage determinations; or

(V) Nationally recognized clinical practice guidelines, consensus statements, and peer-reviewed studies.

(c) The coverage required by this subsection (28) is subject to annual deductibles, copayments, or coinsurance requirements under the health benefit plan but is not subject to any annual or lifetime maximum benefit limit.

(d) The coverage required by this subsection (28) must be provided in a manner that limits unreasonable disruptions in care, including limiting the need for multiple biopsies or biospecimen samples.

(e) Nothing in this subsection (28) shall be construed to require coverage for biomarker testing for screening purposes.

(f) A carrier may require prior authorization for biomarker testing in the same manner that prior authorization is required for any other covered benefit and consistent with section 10-16-112.5.

(g) (I) Within one hundred twenty days after June 3, 2024, the division shall submit to the federal department of health and human services:

(A) A determination as to whether the benefit specified in this subsection (28) is in addition to essential health benefits and would be subject to defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); and

(B) A request that the federal department of health and human services confirm the division's determination within sixty days after receipt of the division's request and submission of its determination.

(II) This subsection (28) applies to, and the division shall implement the provisions of this subsection (28) for, large employer health benefit plans issued or renewed in this state on or after January 1, 2025.

(III) This subsection (28) applies to, and the division shall implement the requirements of this subsection (28) for, individual and small group health benefit plans issued or renewed in this state twelve months after the earlier of the following:

(A) The division receives confirmation from the federal department of health and human services that the coverage specified in this subsection (28) does not constitute an additional benefit that requires defrayal by the state pursuant to 42 U.S.C. sec. 18031 (d)(3)(B);

(B) The federal department of health and human services has otherwise informed the division that the coverage does not require state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B); or

(C) More than three hundred sixty-five days have passed since the division submitted its determination and request for confirmation that the coverage specified in this subsection (28) is not an additional benefit that requires state defrayal pursuant to 42 U.S.C. sec. 18031 (d)(3)(B), and the federal department of health and human services has failed to respond to the request within that period, in which case the division shall consider the federal department of health and human services' unreasonable delay a preclusion from requiring defrayal by the state.

(h) The commissioner shall implement this subsection (28) and shall adopt rules consistent with and as are necessary to implement this subsection (28).

(i) As used in this subsection (28):

(I) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. "Biomarker" includes gene mutations, characteristics of genes, or protein expression.

(II) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. "Biomarker testing" includes single-analyte tests, multiplex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing. "Biomarker testing" does not include direct-to-consumer genetic tests.

(III) "Consensus statements" means statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Consensus statements are developed for specific clinical circumstances and are based on the best available evidence for the purpose of optimizing the outcomes of clinical care.

(IV) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines:

(A) Establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options; and

(B) Include recommendations intended to optimize patient care.

(29) **[*Editor's note: Subsection (29) is effective January 1, 2027.*] Treatment for obesity and pre-diabetes.**

(a) All large group health benefit plans issued or renewed in this state must provide coverage for the treatment of the chronic disease of obesity and the treatment of pre-diabetes, including coverage for a comparable program to the national diabetes prevention program, medical nutrition therapy, intensive behavioral or lifestyle therapy, and metabolic and bariatric surgery.

(b) For a large group health benefit plan offered in this state, a carrier shall offer the policyholder the option to purchase coverage for FDA-approved anti-obesity medications, including at least one FDA-approved GLP-1 medication. This subsection (29) does not require a carrier to offer coverage for which premiums would not cover expected benefits.

(c) The commissioner may adopt rules to implement this subsection (29).

(d) As used in this subsection (29):

(I) "FDA-approved anti-obesity medication" means a medication approved by the federal food and drug administration with an indication for weight management in patients with chronic obesity.

(II) "FDA-approved GLP-1 medication" means a glucagon-like peptide-1 receptor agonist that is approved by the federal food and drug administration with an indication for regulating blood sugar levels and appetite.

(III) "Intensive behavioral or lifestyle therapy" means an evidence-based, multi-component behavioral or lifestyle modification intervention designed to support healthy weight management as recommended by current clinical standards of care. Interventions include obesity screening, dietary assessment, and behavioral counseling and therapy aimed at weight loss through lifestyle modifications such as changes in diet and increased physical activity. Therapy for obesity must be consistent with the United States Preventive Services Task Force's 5-A behavioral counseling framework: Ask, advise, assess, assist, and arrange. Interventions may be provided in-office, virtually through telehealth, or in community-based settings to support patient access and needs.

(IV) "Medical nutrition therapy" means the following nutrition care services that prevent, manage, or treat diseases or medical conditions, which services may be provided in-office or virtually through telehealth:

(A) Nutrition assessment;

(B) Nutrition diagnosis;

(C) Nutrition intervention; and

(D) Nutrition monitoring and evaluation.

(V) "Metabolic and bariatric surgery" means metabolic and bariatric surgery recommended according to the guidelines published in the 2022 American Society for Metabolic and Bariatric Surgery and International Federation for the Surgery of Obesity and Metabolic Disorders: Indications for Metabolic and Bariatric Surgery.

(VI) "National diabetes prevention program" means a structured, evidence-based lifestyle modification program designed to prevent or delay the onset of diabetes in individuals at high risk in accordance with 42 U.S.C. sec. 280g-14. The program follows a standardized curriculum and is focused on promoting healthy lifestyle changes, including weight loss, increased physical activity, and healthier eating habits, through individual and group intervention.

(30) **Gender-affirming health care - rules - definitions.** (a) As used in this subsection (30), unless the context otherwise requires:

(I) "Gender-affirming health care" means all supplies, care, and services of a medical, behavioral health, mental health, psychiatric, habilitative, surgical, therapeutic, diagnostic, preventive, rehabilitative, or supportive nature relating to the treatment of gender dysphoria. "Gender-affirming health care" includes the following, or any combination of the following:

(A) Hormone therapy;

(B) Blepharoplasty, eye and lid;

(C) Face, forehead, or neck skin tightening;

(D) Facial bone remodeling;

(E) Genioplasty;

(F) Rhytidectomy for the cheek, chin, or neck;

(G) Cheek, chin, or nose implants;

(H) Lip lift or augmentation;

(I) Mandibular angle augmentation, creation, or reduction;

(J) Orbital recontouring;

(K) Rhinoplasty;

(L) Laser or electrolysis hair removal;

(M) Breast or chest augmentation, reduction, or construction; and

(N) Genital and nongenital surgical procedures.

(II) "Medically necessary" means a physical or behavioral health-care provider has determined that the prescribed gender-affirming health care is necessary for the treatment of gender dysphoria.

(b) Subject to the requirements set forth in subsection (30)(d) of this section, all health benefit plans issued or renewed in the state shall provide coverage for gender-affirming health care. The health benefit plan must provide the coverage regardless of the covered person's sex or gender.

(c) The commissioner shall adopt rules consistent with and as necessary to implement this subsection (30).

(d) A health benefit plan shall not deny or limit gender-affirming health care that is:

(I) Medically necessary, as determined by the physical or behavioral health-care provider who prescribes the gender-affirming health care; and

(II) Prescribed in accordance with generally accepted standards of care for the profession.

Source: L. 92: Entire article R&RE, p. 1621, § 1, effective July 1; (4)(a) amended, p. 1499, § 32, effective July 1; (4) amended, p. 1752, § 7, effective July 1. **L. 93:** (5)(h) added, p. 956, § 2, effective May 28; (10) added, p. 2090, § 1, effective June 9. **L. 94:** (1.5), (6.5), (6.7) added and (6) amended, p. 1591, § 1, effective July 1; (5)(a), (5)(b)(I), (6), (8)(a), (8)(c), (8)(d), (9)(a)(I), (9)(b)(II), (9)(b)(III), and (9)(c) amended, pp. 2724, 2636, 2604, §§ 321, 77, 2, effective July 1. **L. 95:** IP(4)(a), (4)(a)(II), (4)(a)(III), and (4)(b) amended, p. 486, § 1, effective May 16; (11) added, p. 590, § 1, effective May 22; (10) amended, p. 1389, § 1, effective June 5. **L. 96:** (1)(a) and (1)(b) amended, p. 123, § 1, effective August 7. **L. 97:** (7)(a)(I)(A) amended, p. 1131, § 3, effective May 28; (5.5) added, p. 193, § 1, effective January 1, 1998. **L. 98:** (1)(b) RC&RE and (3)(a) amended, pp. 52, 53, §§ 1, 2, effective March 23; (5)(b)(II), (5)(b)(III), and

(7)(a)(I)(B) amended, p. 1157, § 27, effective July 1; (13) added, p. 329, § 2, effective July 1; (12) added, p. 472, § 2, effective September 1; (6)(c) and (6)(d) amended, p. 1391, § 22, effective February 1, 1999. **L. 99:** (1)(c)(I) and (1)(c)(II)(A) amended and (1)(g) and (1.7) added, pp. 1045, 1046, §§ 1, 2, effective January 1, 2000. **L. 2000:** (14) added, p. 1588, § 1, effective January 1, 2001. **L. 2001:** (5.5)(a)(I) amended, p. 984, § 1, effective August 8; (1)(c)(I) amended and (1)(c)(III) added, p. 931, § 1, effective January 1, 2002. **L. 2003:** (8)(a)(II) amended, p. 700, § 5, effective July 1; (15) added, p. 1774, § 9, effective July 1. **L. 2004:** (5)(c) amended, p. 981, § 4, effective August 4. **L. 2006:** (6.7)(a), (6.7)(b), and (8)(a)(I) amended, p. 1998, § 34, effective July 1; (15) amended, p. 1077, § 3, effective January 1, 2007. **L. 2007:** (17) added, p. 1348, § 3, effective May 29; (16) added, p. 378, § 1, effective August 3; (1.3) added and (1.7)(a) amended, p. 889, § 3, effective January 1, 2008; (5.5)(a) amended and (5.5)(c) added, pp. 1369, 1370, §§ 1, 2, effective January 1, 2008; (15) amended, p. 451, § 3, effective January 1, 2008. **L. 2008:** (1.3)(a) amended, p. 1467, § 12, effective August 5; (6)(a) amended, p. 386, § 2, effective August 5; (7)(a)(I)(B) and (7)(b)(II)(B) amended and (7)(c) added, p. 425, § 24, effective August 5; (19) added, p. 2005, § 1, effective January 1, 2009; (15) amended and (18) added, p. 2074, § 2, effective January 16, 2009. **L. 2009:** (1.3)(a)(VI), (1.3)(b), and (1.3)(e) amended and (1.3)(d.5) and (1.3)(f) added, (HB 09-1237), ch. 216, p. 977, § 1, effective May 2; IP(5), (5)(e), (5)(f), (5)(g), and (5.5)(b) amended, (HB 09-1338), ch. 353, p. 1844, § 4, effective July 1; (1.5), (6)(a), and (6.7)(a) amended, (SB 09-292), ch. 369, p. 1944, § 16, effective August 5; (20) added, (HB 09-1059), ch. 214, p. 969, § 1, effective August 5; (1.5), (4), (15), and (18) amended, (HB 09-1204), ch. 344, p. 1802, § 2, effective January 1, 2010; (1.3)(g) and (1.4) added, (SB 09-244), ch. 391, pp. 2113, 2114, §§ 2, 3, effective July 1, 2010. **L. 2010:** (1.4)(a)(II)(A), (1.4)(a)(VIII), and (1.4)(a)(IX) amended, (HB 10-1260), ch. 403, p. 1978, § 50, effective July 1; (3)(a)(I) amended, (HB 10-1021), ch. 297, p. 1402, § 1, effective January 1, 2011; (18)(b)(III)(D) added, (HB 10-1252), ch. 226, p. 983, § 1, effective January 1, 2011; (21) added, (HB 10-1202), ch. 91, p. 310, § 2, effective January 1, 2011. **L. 2011:** IP(5) and (5)(b)(III) amended, (SB 11-187), ch. 285, p. 1326, § 65, effective July 1; (7)(a)(I)(A) amended, (HB 11-1186), ch. 97, p. 284, § 1, effective January 1, 2012. **L. 2013:** (5)(d)(I) repealed, (HB 13-1015), ch. 38, p. 109, § 2, effective March 15; (1.3)(b)(II), IP(1.3)(b)(IV), (1.3)(d.5), (1.4)(a)(IV), (1.4)(b), (5.5), IP(12)(a), IP(18)(a)(I), (18)(a)(III), IP(18)(b), (18)(b)(III), (18)(b)(VI), (18)(b)(VIII), (18)(b)(IX), and (21)(b) amended, (1.7)(c), (5), (7), (9), (11), (15), (16), and (18)(a)(II) repealed, and (18)(b)(X) added, (HB 13-1266), ch. 217, pp. 920, 978, §§ 3, 28, 27, effective May 13; IP(19)(b) amended, (SB 13-039), ch. 288, p. 1536, § 4, effective May 24; (1.4)(a)(XI) amended, (SB 13-180), ch. 411, p. 2443, § 13, effective June 30; (1.4)(a)(VII) amended, (HB 13-1314), ch. 323, p. 1800, § 18, effective March 1, 2014. **L. 2015:** IP(1.4)(a)(II), (1.4)(a)(II)(E), (1.4)(a)(III), IP(1.4)(a)(XII), (1.4)(b)(I), and (5.5)(a)(IV)(B) amended and (1.4)(a)(II)(F) added, (SB 15-015), ch. 106, p. 308, § 2, effective January 1, 2017. **L. 2016:** (22) added, (HB 16-1095), ch. 12, p. 28, § 1, effective January 1, 2017; (1)(c)(III)(A) and (1)(c)(III)(C) amended, (HB 16-1387), ch. 203, p. 717, § 1, effective January 1, 2018. **L. 2017:** (5.5)(a)(I), (5.5)(a)(IV), and (18)(b)(I) amended, (SB 17-242), ch. 263, p. 1264, § 35, effective May 25; (3)(a)(I) amended, (HB 17-1186), ch. 324, p. 1746, § 2, effective January 1, 2019. **L. 2018:** (1.3)(b)(II)(B) amended, (HB 18-1375), ch. 274, p. 1695, § 3, effective May 29; (6)(b) amended, (SB 18-095), ch. 96, p. 752, § 3, effective August 8; (5.5)(a)(III) amended, (HB 18-1007), ch. 225, p. 1431, § 1, effective January 1, 2019. **L. 2019:** (5.5)(a)(I), (5.5)(a)(IV), (5.5)(b), (5.5)(c), and (18)(b)(I) amended and (5.5)(a)(V) and (5.5)(d) added, (HB 19-1269), ch.

195, p. 2125, § 3, effective May 16; (18)(b)(III) repealed and (18)(b.5) and (18)(c)(III.5) added, (HB 19-1301), ch. 192, p. 2112, § 2, effective August 2; (1.4)(a)(VIII), (1.4)(a)(IX), (1.4)(a)(X), (1.4)(a)(XI), and IP(19)(b) amended, (HB 19-1172), ch. 136, p.1653, § 41, effective October 1. **L. 2020:** (23) added, (HB 20-1158), ch. 106, p. 416, § 2, effective April 1; (5.5)(a)(I) and (5.5)(a)(III)(A) amended and (5.5)(a)(III)(C) added, (SB 20-007), ch. 286, pp. 1389, 1392, §§ 1, 10, effective July 13; (18)(e) added, (HB 20-1061), ch. 281, p. 1375, § 2, effective July 13. **L. 2021:** IP(18)(a)(I) amended and (18)(b.7), (18)(c)(III.7), and (18)(c)(III.9) added, (HB 21-1068), ch. 439, p. 2906, § 2, effective July 6; IP(18)(a)(I) and (18)(a)(III)(A) amended and (18)(b)(XI) and (18.1) added, (SB 21-016), ch. 428, p. 2833, § 1, effective July 6; (3)(d) added, (SB 21-194), ch. 434, p. 2868, § 1, effective September 7; (24) added, (HB 21-1140), ch. 447, p. 2946, § 1, effective September 7; (25) added, (HB 21-1276), ch. 364, p. 2395, § 2, effective January 1, 2023. **L. 2022:** (23)(f) amended, (HB 22-1008), ch. 101, p. 478, § 1, effective April 13; (1.3)(a)(III), (1.3)(a)(VI), and (1.3)(d.5)(I) amended, (HB 22-1295), ch. 123, p. 826, § 21, effective July 1; (5.5)(a)(I)(B) amended, (HB 22-1278), ch. 222, p. 1488, § 4, effective July 1; (5.5)(a)(III)(B) and (21)(a) amended, (HB 22-1264), ch. 126, p. 887, § 1, effective August 10. **L. 2023:** IP(18)(a)(I), IP(18)(b), (18)(b)(X), IP(18)(c), and (18)(e)(I) amended and (18)(b.3), (18)(c)(III.6), (18)(f), and (26) added, (SB 23-189), ch. 69, p. 254, § 2, effective April 14; (14)(d) amended, (HB 23-1136), ch. 268, p. 1589, § 1, effective August 7. **L. 2024:** (24)(a)(II) and (24)(b) amended, (HB 24-1132), ch. 331, p. 2246, § 4, effective June 3; (27) added, (HB 24-1382), ch. 365, p. 2462, § 1, effective June 3; (28) added, (SB 24-124), ch. 364, p. 2458, § 1, effective June 3; (3)(e) added, (SB 24-175), ch. 433, p. 3033, § 1, effective June 5. **L. 2025:** IP(18)(b) and (18)(f) amended and (18)(g) added, (SB 25-196), ch. 182, p. 780, § 1, effective May 12; (30) added, (HB 25-1309), ch. 233, p. 1104, § 1, effective May 23; (18)(b.5) and (18)(c)(III.5)(B) amended, (SB 25-296), ch. 287, p. 1481, § 1, effective August 6; (5.5)(a)(I), (5.5)(a)(V)(A), (5.5)(a)(V)(B), (5.5)(a)(V)(D), (5.5)(b), and (5.5)(d) amended and (5.5)(a)(I.5), (5.5)(a)(V)(F), (5.5)(a)(VI), (5.5)(c.3), (5.5)(c.5), and (5.5)(e) added, (HB 25-1002), ch. 18, p. 70, § 1, effective January 1, 2026; (26)(a) and (26)(d) amended and (26)(f) repealed, (SB 25-183), ch. 97, p. 442, § 1, effective January 1, 2026; (3)(a)(VII) added, (SB 25-118), ch. 284, p. 1468, § 1, effective January 1, 2027; (29) added, (SB 25-048), ch. 365, p. 1980, § 3, effective January 1, 2027.

Editor's note: (1) (a) The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

(b) Subsection (16) was relocated to § 10-16-105 (7) in 2013.

(2) Amendments to subsection (4)(a) by Senate Bill 92-012 were harmonized with amendments to subsection (4) by Senate Bill 92-179.

(3) Amendments to subsection (6) by Senate Bill 94-164 were harmonized with amendments by House Bill 94-1029.

(4) If the commission on mandated health insurance benefits twice fails to reach a quorum to consider the mandated health insurance coverage established by subsection (18) or concludes that the benefits of such mandated health insurance coverage outweigh its harms, amendments to subsections (15) and (18) shall take effect. (See L. 2008, p. 2077.) On January 16, 2009, the revisor of statutes received notice from the division of insurance that the commission was unable to reach a quorum.

(5) Subsection (1.5) was amended in Senate Bill 09-292. Those amendments were superseded by the amendment to subsection (1.5) in House Bill 09-1204, effective January 1, 2010.

(6) Amendments to subsection (18)(a)(I) by HB 21-1068 and SB 21-016 were harmonized.

(7) Section 2(2) of chapter 284 (SB 25-118), Session Laws of Colorado 2025, provides that the act changing this section applies to health insurance policies issued or renewed on or after January 1, 2027.

(8) Section 5(2) of chapter 365 (SB 25-048), Session Laws of Colorado 2025, provides that the act changing this section applies to large group health benefit plans issued or renewed on or after January 1, 2027.

Cross references: (1) For limitations concerning medical or health insurance under the "Colorado Medical Treatment Decision Act", see § 15-18-111; for section 607 of the "Employee Retirement Income Security Act of 1974", see 29 U.S.C. § 1167.

(2) For the legislative declaration contained in the 1993 act adding subsection (5)(h), see section 1 of chapter 211, Session Laws of Colorado 1993. For the legislative declaration contained in the 1998 act adding subsection (12), see section 1 of chapter 162, Session Laws of Colorado 1998. For the legislative declaration contained in the 2006 act amending subsection (15), see section 1 of chapter 236, Session Laws of Colorado 2006. For the legislative declaration contained in the 2008 act amending subsection (15) and adding subsection (18), see section 1 of chapter 411, Session Laws of Colorado 2008. For the legislative declaration contained in the 2009 act adding subsections (1.3)(g) and (1.4), see section 1 of chapter 391, Session Laws of Colorado 2009. For the legislative declaration contained in the 2009 act amending subsections (1.5), (4), (15), and (18), see section 1 of chapter 344, Session Laws of Colorado 2009. For the legislative declaration contained in the 2010 act adding subsection (21), see section 1 of chapter 91, Session Laws of Colorado 2010. For the legislative declaration contained in the 2013 act repealing subsection (5)(d)(I), see section 1 of chapter 38, Session Laws of Colorado 2013. For the legislative declaration in SB 15-015, see section 1 of chapter 106, Session Laws of Colorado 2015. For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in SB 18-095, see section 1 of chapter 96, Session Laws of Colorado 2018. For the legislative declaration in HB 19-1301, see section 1 of chapter 192, Session Laws of Colorado 2019. For the legislative declaration in HB 21-1068, see section 1 of chapter 439, Session Laws of Colorado 2021. For the legislative declaration in HB 21-1276, see section 1 of chapter 364, Session Laws of Colorado 2021.

(3) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019. For the short title ("Colorado Building Families Act") in HB 20-1158, see section 1 of chapter 106, Session Laws of Colorado 2020.

(4) For the short title ("Diabetes Prevention and Obesity Treatment Act") and the legislative declaration in SB 25-048, see sections 1 and 2 of chapter 365, Session Laws of Colorado 2025.

10-16-104.1. Prohibition on discrimination for organ transplants based solely on disability - definition. (1) A carrier that offers, issues, or renews a health benefit plan that provides coverage for anatomical gifts, organ transplants, or related treatments or services shall not, solely on the basis of a covered person's disability:

(a) Deny coverage to a covered person for an organ transplant or related treatment or services;

(b) Decline or limit coverage of a covered person solely for the purpose of avoiding the requirements of this section; or

(c) Penalize a covered person or reduce or limit coverage for a covered person for health-care services related to organ transplantation, as determined in consultation with the attending physician and the covered person or the covered person's representative.

(2) This section does not require a health benefit plan to provide coverage for the donation of an anatomical gift, an organ transplant, or related treatment or services.

(3) For the purposes of this section, "anatomical gift" means the donation of part of a human body for the purpose of transplantation to another person.

Source: L. 2021: Entire section added, (HB 21-1169), ch. 99, p. 400, § 2, effective May 6.

10-16-104.2. Coverage for contraception - rules - definitions. (1) As used in this section, unless the context otherwise requires:

(a) "Carrier" means a carrier offering a health benefit plan.

(b) "Contraception" has the same meaning as "contraceptive" or "contraception" set forth in section 2-4-401 (1.5).

(c) "Dispensing entity" means a pharmacy, other outlet, or other facility registered by the state board of pharmacy under part 1 of article 280 of title 12 that dispenses or furnishes contraception.

(2) As part of the coverage required for contraception pursuant to section 10-16-104 (3)(a)(I), (18), or (18.1), as applicable, a carrier or a pharmacy benefit management firm acting on behalf of the carrier shall provide coverage for, and shall reimburse a provider or an in-network dispensing entity for, the single dispensing or furnishing of contraception intended to last the covered person for a duration of twelve months, as permitted by the covered person's prescription, dispensed or furnished at one time, unless requested otherwise by the covered person.

(3) A carrier or pharmacy benefit management firm acting on behalf of the carrier shall:

(a) Allow for the continuous use of clinically appropriate contraception as determined by the prescribing provider;

(b) Reimburse a provider or an in-network dispensing entity per unit for dispensing or furnishing contraception;

(c) Not implement step therapy, prior authorization, or other utilization management practices, including quantity or fill limits, for contraception coverage if the practice would result in a covered person receiving less than a twelve-months' duration of contraception dispensed or furnished either at one time or, if requested by the covered person at the point of dispensing or furnishing, over a twelve-month period;

(d) Include an alternative prescribed contraception without prior authorization, step therapy, or cost sharing if, in the determination and judgment of the prescribing provider, the alternative prescribed contraception is medically necessary;

(e) Make available an easily accessible, timely, and transparent exceptions process for a covered person to obtain coverage, without cost sharing, for medically necessary contraception that is not otherwise included in the formulary or available without cost sharing;

(f) Not require a prescription for coverage of FDA-approved, -cleared, or -granted over-the-counter contraception; and

(g) Include point-of-sale coverage for over-the-counter contraception at in-network dispensing entities without prior authorization, step therapy, utilization management, or cost sharing.

(4) (a) Carriers shall report annually to the commissioner regarding the coverage of contraception required pursuant to section 10-16-104 (3)(a)(I), (18), or (18.1). At a minimum, the reporting requirements must include annual reporting of data relating to contraception coverage provided in the previous calendar year.

(b) For purposes of the carrier's required reporting to the commissioner pursuant to subsection (4)(a) of this section, a pharmacy benefit management firm acting on behalf of a carrier shall annually provide data to the carrier relating to contraception coverage in the previous calendar year, and the carrier shall include the data provided by a pharmacy benefit management firm in its annual report required by subsection (4)(a) of this section.

(5) The commissioner may promulgate rules to implement this section.

Source: L. 2017: Entire section added, (HB 17-1186), ch. 324, p. 1745, § 1, effective January 1, 2019. **L. 2019:** (2)(a) amended, (HB 19-1172), ch. 136, p. 1654, § 42, effective October 1. **L. 2023:** Entire section R&RE, (SB 23-284), ch. 276, p. 1629, § 1, effective August 7.

10-16-104.3. Health coverage for persons under twenty-six years of age - coverage for students who take medical leave of absence. (1) (a) A carrier that offers a health benefit plan in the state and that makes dependent coverage for children available under the health benefit plan shall make the coverage available for a child who is under twenty-six years of age. The carrier shall not deny or restrict coverage for a child who is under twenty-six years of age based on a factor such as:

(I) Residency with the policyholder or any other person;

(II) The presence or absence of financial dependence on the policyholder or any other person;

(III) Marital or civil union status;

(IV) Student status;

(V) Employment status; or

(VI) A combination of any of the factors listed in paragraphs (a) to (d) of this subsection (1).

(b) A carrier shall not deny dependent coverage of a child based on the child's eligibility for other coverage.

(c) Except as otherwise provided in state law, a carrier offering dependent coverage of children in a health benefit plan shall not vary the terms of coverage in the policy or contract based on age, except for premium rates for children who are twenty-one years of age or older.

(d) Nothing in this subsection (1) requires a carrier to make coverage available for the child of a child receiving dependent coverage unless the grandparent becomes the permanent legal guardian or adoptive parent of that grandchild.

(2) Repealed.

(3) (a) All individual and group sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of part 2 of this article and all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article that provide dependent coverage to a child who is enrolled in a postsecondary educational institution shall not terminate coverage due to a medically necessary leave of absence before the date that is the earlier of:

(I) One year after the first day of the medically necessary leave of absence; or

(II) The date the coverage would otherwise terminate under the terms of the plan or health insurance coverage.

(b) For purposes of this subsection (3), "medically necessary leave of absence" means a leave of absence from a postsecondary educational institution or a change in enrollment of the dependent at the institution that:

(I) Begins while the dependent is suffering from a serious illness;

(II) Is medically necessary; and

(III) Causes the dependent to lose student status for the purpose of dependent coverage.

Source: L. 2005: Entire section added, p. 1503, § 1, effective January 1, 2006. **L. 2009:** (3) added, (HB 09-1338), ch. 353, p. 1844, § 5, effective July 1. **L. 2013:** (1) R&RE and (2) repealed, (HB 13-1266), ch. 217, p. 925, § 4, effective May 13.

10-16-104.4. Child-only plans - legislative declaration - open enrollment - reporting requirements - repeal. (Repealed)

Source: L. 2011: Entire section added, (SB 11-128), ch. 133, p. 468, § 3, effective April 29. **L. 2013:** (2)(b) amended, (HB 13-1266), ch. 217, p. 926, § 5, effective May 13.

Editor's note: Subsection (6) provided for the repeal of this section, effective January 1, 2014. (See L. 2011, p. 468.)

10-16-104.5. Autism - treatment - not mental illness - repeal. (Repealed)

Source: L. 93: Entire section added, p. 956, § 3, effective May 28. **L. 2009:** Entire section amended, (SB 09-244), ch. 391, p. 2118, § 4, effective July 1, 2010. **L. 2015:** (4) added by revision, (SB15-015), ch. 106, p. 310, §§ 3, 4.

Editor's note: Subsection (4) provided for the repeal of this section, effective January 1, 2017. (See L. 2015, p. 310.)

10-16-104.6. Off-label use of cancer drugs. (1) A health benefit plan that provides coverage for prescription drugs shall not limit or exclude coverage for any drug approved by the FDA for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug is prescribed if:

(a) The drug is recognized for treatment of that cancer in the authoritative reference compendia as identified by the secretary of the United States department of health and human services; and

(b) The treatment is for a covered condition.

Source: L. 2010: Entire section added, (HB 10-1355), ch. 229, p. 989, § 1, effective August 11. **L. 2022:** IP(1) amended, (HB 22-1264), ch. 126, p. 888, § 2, effective August 10.

10-16-104.7. Substance use disorders - court-ordered treatment coverage. (1) An individual or group health benefit plan delivered or issued for delivery within this state by an entity subject to the provisions of part 2, 3, or 4 of this article 16 that provides coverage for treatment of a substance use disorder must provide coverage for such treatment regardless of whether the treatment is voluntary or court-ordered as a result of contact with the criminal justice or legal system. The health benefit plan is only required to provide coverage for benefits that are medically necessary and otherwise covered under the plan. Such coverage is subject to copayment, deductible, and policy maximums and limitations. Health benefit plans issued by an entity subject to the provisions of part 4 of this article 16 may provide that the benefits required pursuant to this section are covered benefits only if the services are deemed medically necessary and are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(2) Nothing in this section mandates or is meant to construe that any health benefit plan must provide coverage for treatment of a substance use disorder.

Source: L. 2002: Entire section added, p. 750, § 1, effective January 1, 2003. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1264, § 36, effective May 25.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

10-16-104.8. Behavioral, mental health, or substance use disorder services coverage - court-ordered. (1) An individual or group health benefit plan delivered or issued for delivery within this state by an entity subject to the provisions of part 2, 3, or 4 of this article 16 that provides coverage for behavioral, mental health, or substance use disorder services must provide coverage for behavioral, mental health, or substance use disorder services regardless of whether the services are voluntary or court-ordered as a result of contact with the criminal justice or juvenile justice system. The health benefit plan is required to provide coverage only for benefits that are medically necessary and otherwise covered under the plan. Such coverage is subject to applicable in- or out-of-network copayment, deductible, and policy maximums and limitations. The court order for behavioral, mental health, or substance use disorder services must not mandate the type of behavioral, mental health, or substance use disorder services or the length and frequency of treatment that is to be covered by the health benefit plan. The health benefit

plan is only responsible for those benefits that are covered by the health benefit plan and not those that are court-ordered that exceed the scope of benefits as provided by the health plan. Determination of medically necessary behavioral, mental health, or substance use disorder services must be made by the health benefit plan based on the submitted clinical treatment plan from a provider who is designated by and affiliated with the health benefit plan. Health benefit plans issued by an entity subject to the provisions of part 4 of this article 16 may provide that the benefits required pursuant to this section are covered benefits only if the services are deemed medically necessary and are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(2) Nothing in this section mandates or is meant to construe that a health benefit plan provide coverage for behavioral, mental health, or substance use disorder services.

(3) For purposes of this section, "behavioral, mental health, or substance use disorder services" includes the prevention of, screening for, and treatment of behavioral, mental health, or substance use disorders as described in section 10-16-104 (5.5).

(4) For purposes of this section, "behavioral, mental health, or substance use disorder services" does not include services that are outside the scope of the contract. Such behavioral, mental health, or substance use disorder services that are outside the scope of the contract may include: Services that are custodial or residential in nature, probation assessments, testing for ability, aptitude, or intelligence, or performing evaluations, such as placement evaluations, custody evaluations, reunification assessments, or community risk assessments for any purpose other than treatment of behavioral, mental health, or substance use disorders.

Source: L. 2006: Entire section added, p. 159, § 1, effective March 31. **L. 2013:** (3) amended, (HB 13-1266), ch. 217, p. 988, § 47, effective May 13. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1265, § 37, effective May 25. **L. 2019:** (3) amended, (HB 19-1269), ch. 195, p. 2128, § 4, effective May 16.

Cross references: (1) For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

(2) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

10-16-104.9. Geographic areas for small employers. (1) The commissioner shall promulgate a rule concerning geographic case characteristics, which may include metropolitan statistical areas for small employers. In promulgating such rule, the commissioner shall take testimony from all interested parties, including, but not limited to, consumer advocates and consumers, insurers, health-care providers, the state demographer, and producers. The rule shall include, without limitation, the following features:

(a) If the rule establishes separate geographic areas, in rate filings to the commissioner, a carrier shall be required to show that rates reflect a relativity to rates for other areas in the state and that rates and relativities are not excessive, inadequate, or unfairly discriminatory in such geographic areas;

(b) The rule shall contain a determination of the appropriate population base for statistical reliability in determining geographic areas or metropolitan statistical areas;

(c) (I) The rule shall provide justifications of why any separate geographic areas, which may include metropolitan statistical areas, serve the public interest in regard to ensuring that premium rates for different geographic areas of the state are not excessive, inadequate, or unfairly discriminatory;

(II) If the commissioner determines that metropolitan statistical areas are no longer the best method for addressing geographic case characteristics, the commissioner shall provide detailed justifications concerning the separate geographic areas, in connection with which the commissioner shall make public the impact the geographic case characteristics may have on insurance premiums for the separate geographic areas; and

(d) In adopting such rule, the commissioner may consider the cost of health care in a geographic area, experience of health care of any separate geographic area, and information including actuarial opinions or certifications and set loss ratios for loss ratio guarantees submitted by small employer carriers pursuant to section 10-16-107 (1). The cost of health care and experience and the population that may be served may be a consideration when determining whether separate geographic case characteristics are necessary, but shall not be the sole factors of separate geographic case characteristics, nor shall it compromise the public interest of insureds and potential insureds of this state.

Source: L. 2002: Entire section added, p. 1294, § 7, effective June 7. **L. 2003:** (1)(c)(I) amended, p. 1988, § 21, effective May 22.

Editor's note: This section was originally enacted as § 10-16-104.7 in House Bill 02-1003 but has been renumbered on revision for ease of location.

10-16-105. Guaranteed issuance of health insurance coverage - individual and small employer health benefit plans. (1) (a) (I) Subject to subsections (2) and (4) to (6) of this section, each carrier that offers an individual health benefit plan in this state shall issue any applicable health benefit plan to any eligible individual who applies for the plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health benefit plan consistent with this article.

(II) During any period of open enrollment, a carrier shall offer child-only plan coverage to all applicants under twenty-one years of age on a guaranteed-issuance basis.

(b) (I) Subject to subsections (2) to (6) of this section, each carrier that offers a small employer health benefit plan in this state shall issue any small employer health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health benefit plan not inconsistent with this article.

(II) A carrier offering small employer health benefit plans as described in subparagraph (I) of this paragraph (b):

(A) Shall offer coverage to all of the eligible employees of the eligible small employer and the employees' dependents, if the small employer offers dependent coverage to its employees, who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan; and

(B) Shall not offer coverage to only certain individuals or dependents in the small group or to only part of the small group.

(2) A carrier offering individual or small employer health benefit plans:

(a) May restrict enrollment in an individual or small employer health benefit plan to open or special enrollment periods; and

(b) Shall establish special enrollment periods for triggering or qualifying events consistent with section 10-16-105.7 and in accordance with rules adopted by the commissioner.

(3) A carrier offering small employer health benefit plans:

(a) Shall not apply any waiting period that exceeds ninety days;

(b) Shall apply any requirements it uses to determine whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, uniformly among all small employers with the same number of eligible employees applying for or receiving coverage from the small employer carrier;

(c) May vary the application of minimum participation requirements and minimum employer contribution requirements based on the size of the small employer group and by product;

(d) In applying minimum participation requirements with respect to a small employer, shall not consider employees or dependents who have creditable group coverage or individual coverage that has been consistently maintained and that was in force before the individual's eligibility for group coverage under an existing group plan when determining whether the applicable percentage of participation is met. However, a small employer carrier may consider employees or dependents of the small employer who have coverage under another health benefit plan that is sponsored by the small employer.

(e) Shall not increase any requirement for minimum employee participation or for minimum employer contribution with respect to a small employer at any time after the small employer carrier accepts the small employer for coverage.

(4) (a) Subject to paragraph (c) of this subsection (4), with respect to coverage offered through a managed care plan, a carrier is not required to offer coverage under that plan or accept applications for that plan pursuant to subsection (1) of this section in the following situations:

(I) In an area outside of the carrier's established geographic service area for the managed care plan;

(II) (A) Under an individual health benefit plan, to an individual when the individual does not live or reside within the carrier's established geographic service area for the managed care plan; or

(B) Under a small employer health benefit plan, to an employee when the employee does not live, work, or reside within the carrier's established geographic service area for the managed care plan; or

(III) Within the geographic service area for the managed care plan where the carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to any additional individuals and the members of the small employer groups because of its obligations to existing covered persons.

(b) A carrier that cannot offer coverage pursuant to subparagraph (III) of paragraph (a) of this subsection (4) shall not offer coverage in the individual or small group market in the applicable geographic service area to new individuals or small employer groups until the later of:

(I) One hundred eighty days following each refusal; or

(II) The date on which the carrier notifies the commissioner that it has regained capacity to deliver services.

(c) A carrier shall apply the requirements of this subsection (4) uniformly to all individuals and small employers in this state consistent with applicable law and without regard to the claims experience of or any health-status-related factor relating to an individual and his or her dependents or the small employer and its employees and their dependents.

(5) (a) A carrier offering individual or small employer health benefit plans is not required to provide coverage if:

(I) For any period of time, the carrier demonstrates, and the commissioner determines, that the carrier does not have the financial reserves necessary to underwrite additional coverage; and

(II) The carrier is applying this subsection (5) uniformly to all individuals in the individual market and to all small employers in the small group market in this state consistent with applicable state law and without regard to the claims experience of or any health-status-related factor relating to the individual and his or her dependents or the small employer and its employees and their dependents.

(b) A carrier that denies coverage in accordance with paragraph (a) of this subsection (5) shall not offer coverage in the applicable individual market or small group market in this state until the later of:

(I) One hundred eighty days after the date the coverage is denied; or

(II) The date on which the carrier demonstrates to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

(6) This section does not require a carrier:

(a) Offering health benefit plans only in connection with group health plans to offer coverage in the individual market;

(b) Offering health benefit plans only in connection with individual health plans to offer coverage in the small group market;

(c) Offering health benefits plans only through one or more bona fide associations to offer coverage in the individual market. However, if the carrier offers bona fide association health benefit plan coverage in the individual market, the health carrier shall offer the coverage to eligible individuals in the individual market as required under paragraph (a) of subsection (1) of this section; or

(d) Offering only student health insurance coverage to otherwise offer coverage in the individual market, as long as the carrier is offering student health insurance coverage consistent with the provisions of federal law.

(7) **Issuance of coverage to members of military.** (a) All sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall not refuse to provide coverage to an individual, refuse to continue to cover an individual, or limit the amount or extent of coverage available to an individual solely based on that individual's membership in the uniformed services of the United States. Nothing in this section prohibits a carrier from excluding or limiting coverage for some other factor permitted by law.

(b) As used in this subsection (7), unless the context otherwise requires:

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

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

(8) **Domestic partner coverage.** Notwithstanding any provision of law to the contrary, a small employer carrier may offer, and a small employer may accept or reject, coverage for employees' domestic partners and their dependents or for employees' designated beneficiaries and their dependents.

Source: L. 92: Entire article R&RE, p. 1634, § 1, effective July 1. **L. 94:** (8) amended and (6.5), (6.6), (7.2), (7.3), (7.4), (7.5), (7.6), (8.1), (8.2), (10), and (11) added, p. 1902, § 7, effective July 1. **L. 96:** (9) and (10) repealed, p. 1230, § 51, effective August 7. **L. 97:** (8)(a)(I) and (8)(a)(VII) amended and (8)(a)(X), (8)(a)(XI), and (8)(a)(XII) added, p. 210, § 4, effective April 8; (3) to (5), (7.3)(a), IP(7.3)(b)(I), (7.3)(c)(I), (7.3)(d.5), (7.3)(e), (7.3)(h), and (7.4)(c) amended and (12) added, p. 633, § 4, effective May 1. **L. 99:** (8)(a)(I), (8)(a)(VII), (8)(a)(X), and (8)(a)(XI) amended, p. 147, § 2, effective March 25; (7.3)(a) and (7.3)(c)(I) amended and (7.3)(b)(V) and (7.3)(i) added, pp. 226, 227, §§ 2, 3, effective August 4. **L. 2001:** (7.3)(b)(IV) and (11) amended, p. 1167, § 1, effective July 1; (7.4)(c) amended, p. 812, § 3, effective January 1, 2002. **L. 2002:** (7.2), (7.4)(c), (7.6)(a)(I), IP(8)(f), and (8)(f)(II) amended, p. 1291, § 3, effective January 1, 2003; IP(7.3)(c)(II) amended and (7.3)(c)(IV) added, p. 331, § 3, effective January 1, 2003. **L. 2003:** (8)(f)(II) amended, p. 1988, § 22, effective May 22; (5)(g), (8.5), and (8.7) added and (7.2) and (7.5)(a) amended, pp. 1778, 1775, §§ 11, 10, effective July 1; (8)(a)(VIII), (8)(e), and IP(8)(f) amended and (13), (14), and (15) added, p. 2691, § 1, effective January 1, 2004. **L. 2004:** (7.2)(b), (7.3)(c)(II), and (7.3)(c)(III) amended, p. 762, § 1, effective July 1; (5)(a), (5)(c), (5)(f), (6.5), (6.6), (7), (7.3)(b)(I), (7.3)(b)(II), (7.3)(b)(III), (7.3)(c), (7.3)(g), (8)(a), (8)(b), (8)(c)(I), (8)(e), (8.1), (8.2), and (8.5)(c) amended, p. 981, § 5, effective August 4. **L. 2005:** (7.2)(c) added, p. 1030, § 1, effective June 2; (13)(a)(I)(G) added, p. 421, § 2, effective January 1, 2006. **L. 2006:** (7.4)(b) amended, p. 223, § 1, effective March 31; (16) added, p. 1075, § 2, effective May 25; (7.6)(a)(I) amended, p. 1491, § 15, effective June 1; (11) amended, p. 1075, § 2, effective July 1; IP(7.2) and (7.2)(b) amended, p. 1075, § 2, effective January 1, 2007. **L. 2007:** IP(13)(a)(I) amended, p. 2052, § 109, effective June 1; (5)(g), (7.2)(b)(I), (7.2)(b)(III), and (7.2)(b)(IV)(A) amended, pp. 449, 450, §§ 1, 2, effective January 1, 2008; (5)(g)(I) amended, p. 892, § 4, effective January 1, 2008; (8.5)(a)(II)(C) added, p. 1754, § 3, effective January 1, 2008; (5)(a), (8)(e), IP(8.5)(a), (8.5)(a)(I)(A), (8.5)(a)(V), (8.5)(c), (8.7)(a)(I), (8.7)(a)(III), and (8.7)(b), amended, p. 1752, § 2, effective January 1, 2009. **L. 2008:** (6) and (6.6) amended, p. 2250, § 4, effective July 1; IP(7.2) amended, p. 386, § 3, effective August 5; IP(8.7)(b) amended, p. 1881, § 13, effective August 5; (7.2)(b)(I), (7.2)(b)(III), IP(7.2)(b)(IV), and (7.2)(b)(IV)(A) amended, p. 2076, § 3, effective January 16, 2009. **L. 2009:** (7.2)(c) amended, (HB 09-1260), ch. 107, p. 440, § 4, effective July 1; IP(13)(a)(I), (13)(a)(I)(D), (13)(a)(I)(E), and (13)(a)(I)(F) amended, (SB 09-292), ch. 369, p. 1944, § 17, effective August 5; (7.2)(b)(I), (7.2)(b)(II), (7.2)(b)(III), (7.2)(b)(IV)(A), and (7.2)(b)(IV)(C) amended, (HB 09-1204), ch. 344, p. 1806, § 4, effective January 1, 2010. **L. 2011:** (16) repealed, (SB 11-103), ch. 43, p. 112, § 2, effective March 21. **L. 2013:** Entire section R&RE, (HB 13-1266), ch. 217, p. 926, § 6, effective May 13. **L. 2021:** (7)(b)(II) amended, (HB 21-1231), ch. 206, p. 1077, § 3, effective May 28.

Editor's note: (1) (a) The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

(b) Subsection (7) is similar to former § 10-16-104 (16) as it existed prior to 2013.

(c) In 2013, former subsections (8)(c)(II) and (8)(d) were relocated to § 10-16-107 (6)(b) and (6)(c); former subsection (12) was relocated to § 10-16-102 (61)(e); former subsection (13)(a) was relocated to § 10-16-105.6 (3)(a), (3)(b), and (3)(c); former subsection (13)(d) was relocated to § 10-16-105.6 (3)(d); and former subsection (14)(a) was relocated to § 10-16-105.6 (4).

(2) Section 8(1) of Senate Bill 06-036 provided that subsection (7.2)(b) is effective January 1, 2007; except that section 8(2)(c) of Senate Bill 06-036 provided that subsection (7.2)(b)(IV) is effective January 1, 2008.

(3) Amendments to subsection (5)(g)(I) by Senate Bill 07-004 and Senate Bill 07-078 were harmonized.

(4) If the commission on mandated health insurance benefits twice fails to reach a quorum to consider the mandated health insurance coverage established by section 10-16-104 (18) or concludes that the benefits of such mandated health insurance coverage outweigh its harms, amendments to subsections (7.2)(b)(I), (7.2)(b)(III), IP(7.2)(b)(IV), and (7.2)(b)(IV)(A) shall take effect. (See L. 2008, p. 2077.) On January 16, 2009, the revisor of statutes received notice from the division of insurance that the commission was unable to reach a quorum.

(5) Subsection (8.5)(a)(II)(C) provided for the repeal of subsection (8.5)(a)(II)(C), effective January 1, 2009. (See L. 2007, p. 1754.)

Cross references: For the legislative declaration contained in the 1996 act repealing subsections (9) and (10), see section 1 of chapter 237, Session Laws of Colorado 1996. For the legislative declaration contained in the 1997 act amending subsections (8)(a)(I) and (8)(a)(VII) and enacting subsections (8)(a)(X), (8)(a)(XI), and (8)(a)(XII), see section 1 of chapter 77, Session Laws of Colorado 1997. For the legislative declaration contained in the 1997 act amending subsections (3) to (5), (7.3)(a), IP(7.3)(b)(I), (7.3)(c)(I), (7.3)(d.5), (7.3)(e), (7.3)(h), and (7.4)(c) and enacting subsection (12), see section 1 of chapter 154, Session Laws of Colorado 1997. For the legislative declaration contained in the 2002 act amending subsection IP(7.3)(c)(II) and enacting subsection (7.3)(c)(IV), see section 1 of chapter 117, Session Laws of Colorado 2002. For the legislative declaration contained in the 2005 act enacting subsection (13)(a)(I)(G), see section 1 of chapter 127, Session Laws of Colorado 2005. For the legislative declaration contained in the 2006 act amending the introductory portion to subsection (7.2) and subsections (7.2)(b) and (11) and enacting subsection (16), see section 1 of chapter 236, Session Laws of Colorado 2006. For the legislative declaration contained in the 2008 act amending subsections (7.2)(b)(I), (7.2)(b)(III), the introductory portion to (7.2)(b)(IV), and (7.2)(b)(IV)(A), see section 1 of chapter 411, Session Laws of Colorado 2008. In 2008, subsections (6) and (6.6) were amended by the "Fair Accountable Insurance Rates Act". For the short title and legislative declaration, see sections 1 and 2 of chapter 439, Session Laws of Colorado 2008. For the legislative declaration contained in the 2009 act amending subsections (7.2)(b)(I), (7.2)(b)(II), (7.2)(b)(III), (7.2)(b)(IV)(A), and (7.2)(b)(IV)(C), see section 1 of chapter 344, Session Laws of Colorado 2009.

10-16-105.1. Guaranteed renewability - exceptions - individual and small employer health benefit plans - rules - notice to revisor of statutes. (1) Except as otherwise provided in subsection (2) of this section, a carrier providing coverage under a health benefit plan shall renew or continue the coverage at the option of the policyholder.

(2) A carrier may refuse to renew or discontinue coverage under a health benefit plan only for the following reasons:

(a) Nonpayment of the required premium or failure to timely pay premiums in accordance with the terms of the health benefit plan;

(b) The policyholder or the policyholder's representative has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of coverage;

(c) For small group health benefit plans, the policyholder fails to comply with the carrier's minimum participation or employer contribution requirements or the small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan;

(d) In the case of a carrier that offers coverage through a managed care plan, there are no longer any enrolled individuals or employees living, working, or residing within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant section 10-16-105 (4)(a)(III);

(e) In the case of an individual or small employer health benefit plan that is made available only through one or more bona fide associations, the membership of the policyholder or small employer in the association on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph (e) uniformly without regard to any health-status-related factor relating to any covered person;

(f) In the case of individual health benefit plans that are made available as student health insurance coverage, the student policyholder covered under the coverage ceases to be a student at the institution of higher education through which the student health insurance coverage is offered, as long as the coverage is terminated under this paragraph (f) uniformly without regard to any health-status-related factor related to any covered person;

(g) The carrier elects to discontinue offering a particular individual or small group health benefit plan, but only if the carrier:

(I) Provides notice of the decision not to renew coverage at least ninety days before the nonrenewal of the health benefit plan to each policyholder, individual, certificate holder, participant, or beneficiary covered by the plan;

(II) Offers each policyholder covered by the plan the option to purchase any other health benefit plans currently being offered by the carrier in this state and specifies the special enrollment periods for the plans pursuant to section 10-16-105.7;

(III) In exercising the option to discontinue that particular type of health benefit plan, acts uniformly without regard to the claims experience of the policyholders or any health-status-related factor relating to any individual, participant, or beneficiary covered by the plan or new individuals, participants, or beneficiaries who may become eligible for coverage;

(IV) Provides notice to the commissioner before providing the notice pursuant to subparagraph (I) of this paragraph (g) and certifies the following to the commissioner:

(A) The premiums for other health benefit plans the carrier offers pursuant to subparagraph (II) of this paragraph (g) are not excessive, inadequate, or unfairly discriminatory relative to the plan that the carrier is discontinuing; and

(B) The benefit levels the carrier offers in the other health benefit plans comply with the requirements of law applicable to individual and small employer health benefit plans; or

(h) (I) The carrier elects to discontinue offering and renewing all of its individual, small group, or large group health benefit plans delivered or issued for delivery in this state, but only if the carrier:

(A) Provides notice of the decision to discontinue coverage, at least one hundred eighty days before the discontinuance, to all policyholders and covered persons; and

(B) Provides the notice to the commissioner at least three business days before the date the notice is sent to the affected policyholders and covered persons pursuant to sub-subparagraph (A) of this subparagraph (I).

(II) In the case of a discontinuance under subparagraph (I) of this paragraph (h), the carrier shall:

(A) Continue to provide coverage through the first renewal period not to exceed twelve months after the notice provided pursuant to subparagraph (I) of this paragraph (h); and

(B) Not write new health benefit plans of the same type as those the carrier discontinued in this state for five years after the date of the notice to the commissioner pursuant to sub-subparagraph (B) of subparagraph (I) of this paragraph (h).

(3) A carrier offering individual or small employer health benefit plans shall clearly disclose in its contracts and marketing materials the conditions of renewability, which conditions must conform with the requirements of this section.

(3.5) (a) **[*Editor's note: This version of subsection (3.5)(a) is effective until January 1, 2026.*]** If a carrier issues a small group health benefit plan to a small employer that, at the time the plan was issued, was a small employer but subsequently employs more than one hundred eligible employees, this article 16 and any rules promulgated by the commissioner concerning small group health benefit plans continue to apply to the health benefit plan as long as the employer renews its current small group health benefit plan or a similar plan offered by the carrier pursuant to subsection (3.5)(b) of this section, in accordance with the renewal requirements applicable to other small group health benefit plans subject to this article 16 and rules promulgated by the commissioner pursuant to this article 16.

(3.5) (a) **[*Editor's note: This version of subsection (3.5)(a) is effective January 1, 2026.*]** If a carrier issues a small group health benefit plan to a small employer that, at the time the plan was issued, was a small employer but subsequently employs more than fifty eligible employees, this article 16 and any rules promulgated by the commissioner concerning small group health benefit plans continue to apply to the health benefit plan as long as the employer renews its current small group health benefit plan or a similar plan offered by the carrier pursuant to subsection (3.5)(b) of this section, in accordance with the renewal requirements applicable to other small group health benefit plans subject to this article 16 and rules promulgated by the commissioner pursuant to this article 16.

(b) **[*Editor's note: This version of subsection (3.5)(b) is effective until January 1, 2026.*]** If a small employer was issued a small group health benefit plan and subsequently employs more than one hundred employees and the employer opts to renew the small group health benefit plan, the carrier that issued the small group health benefit plan shall offer the

employer the same small group health benefit plan or, if the same plan is no longer being offered to any small employer, a similar small group health benefit plan that the carrier offers to other small employers.

(b) **[*Editor's note: This version of subsection (3.5)(b) is effective January 1, 2026.*]** If a small employer was issued a small group health benefit plan and subsequently employs more than fifty employees and the employer opts to renew the small group health benefit plan, the carrier that issued the small group health benefit plan shall offer the employer the same small group health benefit plan or, if the same plan is no longer being offered to any small employer, a similar small group health benefit plan that the carrier offers to other small employers.

(c) **[*Editor's note: This version of subsection (3.5)(c) is effective until January 1, 2026.*]** A carrier that issued a small group health benefit plan to a small employer shall notify the employer, within sixty days after becoming aware that the employer employs more than one hundred employees, but no later than the anniversary date of the issuance of the employer's health benefit plan, that the provisions of Colorado law governing small group health benefit plans will cease to apply to the employer if the employer fails to renew its current small group health benefit plan or elects to enroll in a different health benefit plan.

(c) **[*Editor's note: This version of subsection (3.5)(c) is effective January 1, 2026.*]** A carrier that issued a small group health benefit plan to a small employer shall notify the employer, within sixty days after becoming aware that the employer employs more than fifty employees, but no later than the anniversary date of the issuance of the employer's health benefit plan, that the provisions of Colorado law governing small group health benefit plans will cease to apply to the employer if the employer fails to renew its current small group health benefit plan or elects to enroll in a different health benefit plan.

(d) **[*Editor's note: Subsection (3.5)(d) is effective January 1, 2026.*]**

(I) If an employer was issued a small group health benefit plan before January 1, 2026, and employs between fifty-one and one hundred employees, the employer may elect to remain in the small group health benefit market for five years after the date of the issuance of the employer's existing health benefit plan or elect to enter the large group health benefit market at the expiration of the employer's existing health benefit plan.

(II) (A) An employer that was issued a small group health benefit plan before January 1, 2026, and employs between fifty-one and one hundred employees may switch between small group health benefit plans being offered by the carrier for five years after the date of the issuance of the employer's health benefit plan.

(B) An employer that switches between small group health benefit plans offered by the carrier must switch to a small group health benefit plan that is one metal level above or below the employer's existing small group health benefit plan.

(III) If an employer that was issued a small group health benefit plan before January 1, 2026, and employs between fifty-one and one hundred employees elects to enter the large group health benefit market and not to continue receiving coverage under a small group health benefit plan before the expiration of the five-year period described in subsection (3.5)(d)(I) of this section, the employer may not switch back to receiving small group health benefit coverage within the five-year period and is classified as a large employer, as defined in section 10-16-102 (40.5).

(e) (I) On or before July 1, 2025, carriers offering small group health benefit plans shall submit to the commissioner two rate filings for plan year 2026. The two rate filings must

demonstrate the impact of Senate Bill 24-073, enacted in 2024, on premiums for small group health benefit plans for employers with fewer than fifty-one eligible employees.

(II) This subsection (3.5), section 10-16-102 (40.5) and (61), and section 10-16-1401 (15), as amended by Senate Bill 24-073, enacted in 2024, will be repealed if the rate filings submitted by carriers pursuant to subsection (3.5)(e)(I) of this section demonstrate that the premiums for the majority of individuals covered by small group health benefit plans would increase by more than three percent after accounting for normal premium trends for small group health benefit plans.

(III) The commissioner shall notify the revisor of statutes in writing of the date when the conditions specified in subsection (3.5)(e)(II) of this section have occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. This subsection (3.5), section 10-16-102 (40.5) and (61), and section 10-16-1401 (15), as amended by Senate Bill 24-073, enacted in 2024, are repealed upon the date identified in the notice that the conditions specified in subsection (3.5)(e)(II) of this section have occurred or, if the notice does not specify that date, upon the date of the notice to the revisor of statutes.

(IV) Notwithstanding section 10-16-155, the commissioner shall utilize resources allocated for actuarial review pursuant to section 10-16-155 to analyze the rate filings submitted by carriers pursuant to subsection (3.5)(e)(I) of this section.

(4) A carrier offering a large group health benefit plan may modify the plan at renewal if the carrier modifies the plan uniformly for all large groups covered by the same plan.

(5) With respect to benefits provided under an individual or small employer health benefit plan, a carrier may make reasonable modifications if:

(a) The modification is effective only upon renewal of the plan;

(b) The carrier modifies the benefits uniformly for all individuals and groups covered by the plan;

(c) The carrier provides the proposed modification to policyholders and the commissioner at least ninety days before the effective date of the modification; and

(d) The carrier provides each affected policyholder the opportunity to purchase any other health benefit plan offered by the carrier.

(6) (a) The commissioner may promulgate rules as necessary to implement and administer this section.

(b) Repealed.

Source: L. 2013: Entire section added, (HB 13-1266), ch. 217, p. 930, § 7, effective May 13. **L. 2021:** (3.5) added, (SB 21-090), ch. 21, p. 104, § 1, effective September 7. **L. 2024:** (3.5) amended, (SB 24-073), ch. 146, p. 590, § 2, effective January 1, 2026 (see editor's note).

Editor's note: (1) Subsection (6)(b)(II) provided for the repeal of subsection (6)(b), effective January 1, 2015. (See L. 2013, p. 930.)

(2) Section 5 of chapter 146, (SB 24-073), Session Laws of Colorado 2024, provides that subsection (3.5)(e) takes effect May 1, 2024, and the remainder of subsection (3.5) takes effect January 1, 2026.

10-16-105.2. Small employer health insurance availability program. (1) (a) Except as provided in paragraphs (b) and (d) of this subsection (1), this article applies to any health

benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(I) Any portion of the premium or benefit is paid by or on behalf of a small employer;

(II) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of a small employer for any portion of the premium;

(III) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the federal "Internal Revenue Code of 1986", as amended, except as provided in paragraph (d) of this subsection (1); or

(IV) The plan is marketed to individual employees through an employer or at a place of business, except as otherwise allowed by rule. The division of insurance shall promulgate a rule to allow, with the permission of or at the request of the employer:

(A) Agents to market health benefit plans through an employer or at an employer's place of business to such employer's ineligible employees;

(B) Small employer carriers to market individual health benefit plans through an employer or at an employer's place of business to such employer's ineligible employees and to dependents of eligible employees when the carrier has group coverage in place with the employer.

(b) The provisions of this article shall not apply to a multiple employer health trust, as set forth in section 10-3-903.5 (7)(b), or a multiple employer welfare arrangement, as set forth in section 10-3-903.5 (7)(c).

(c) Repealed.

(d) A plan shall not be subject to the small group provisions of this article if the premium for the plan is paid for through a section 125 plan or program of the federal "Internal Revenue Code of 1986", as amended, the employer makes no contribution to the section 125 plan or program, the employer does not have in place an employer-sponsored health benefit plan, and the employer does not pay for any portion of the premium or benefit paid.

(1.5) Notwithstanding any other provision of law, a small employer that does not have, and has not had in the previous twelve months, a small group health benefit plan providing coverage to its employees under this article may reimburse an employee, whether through wage adjustments or health reimbursement arrangements, for any portion of the premium for a health coverage plan.

(2) (a) Except as provided in paragraph (b) of this subsection (2), carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this article shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.

(b) An affiliated carrier that is a health maintenance organization having a certificate of authority under this article may be considered to be a separate carrier for purposes of this subsection (2).

(c) Part 7 of article 3 of this title applies if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.

(3) and (4) Repealed.

Source: L. 2004: Entire section added, p. 986, § 6, effective August 4; (1)(c)(I)(A) amended, p. 1214, § 109, effective August 4. **L. 2011:** (1.5) added, (SB 11-019), ch. 78, p. 214, § 1, effective March 29. **L. 2013:** IP(1)(a) amended and (1)(c), (3), and (4) repealed, (HB 13-1266), ch. 217, p. 933, § 8, effective May 13. **L. 2014:** (2)(c) amended, (HB 14-1315), ch. 295, p. 1218, § 8, effective January 1, 2015.

10-16-105.3. Health benefit plans - not prohibited. (1) A carrier shall not be prohibited from offering to a small employer additional options of health benefit plans that:

(a) Provide for different benefits for insureds and dependents of such insureds covered by the same policy; and

(b) Encourage appropriate health-care condition management based on clinical guidelines by providing case management benefits to covered persons.

Source: L. 2003: Entire section added, p. 1778, § 12, effective January 1, 2004.

10-16-105.5. Individual health plans - federally eligible individual - limited guarantee issue. (Repealed)

Source: L. 97: Entire section added, p. 637, § 5, effective May 1. **L. 2001:** (1) and (2) amended, p. 1049, § 32, effective June 5. **L. 2009:** (2) amended, (HB 09-1349), ch. 377, p. 2052, § 2, effective June 1. **L. 2013:** Entire section repealed, (HB 13-1266), ch. 217, p. 978, § 28, effective May 13.

10-16-105.6. Rate usage. (1) A carrier offering an individual or group health benefit plan shall not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or, for group plans, a contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health-status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) The prohibition in subsection (1) of this section does not:

(a) Restrict the amount that a carrier may charge an employer for coverage under a group health benefit plan; or

(b) Prevent a carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for adherence to programs of health promotion and disease prevention if otherwise allowed by state or federal law.

(3) Repealed.

(4) A small employer carrier may impose a premium surcharge of up to thirty-five percent above the modified community rate on a small employer group whose small group insurance has been discontinued because of nonpayment of premiums or fraud. The small employer carrier may impose the premium surcharge when the small business group reapplies for coverage in the small group market. A small employer carrier may require the increased premium to apply to the small business group for up to twelve months.

Source: L. 2013: Entire section added with relocations, (HB 13-1266), ch. 217, p. 934, § 9, effective May 13. **L. 2016:** (2)(b) amended, (SB 16-189), ch. 210, p. 756, § 14, effective June 6. **L. 2017:** (3) repealed, (SB 17-249), ch. 283, p. 1549, § 19, effective June 1.

Editor's note: Subsections (1) and (2) are similar to former § 10-16-107 (6); subsections (3)(a), (3)(b), and (3)(c) are similar to former § 10-16-105 (13)(a); subsection (3)(d) is similar to former § 10-16-105 (13)(d); and subsection (4) is similar to former § 10-16-105 (14)(a), as those sections existed prior to 2013.

10-16-105.7. Health benefit plan open enrollment periods - special enrollment periods - rules. (1) (a) A carrier offering an individual health benefit plan in this state shall permit an individual to purchase an individual health benefit plan during the initial and annual open enrollment periods.

(b) The initial open enrollment period begins October 1, 2013, and extends through March 31, 2014.

(c) For benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year.

(d) For purposes of this subsection (1), the benefit year for health benefit plans purchased during the initial and annual enrollment periods is a calendar year.

(e) The commissioner shall establish rules in accordance with federal law for the implementation of this subsection (1).

(2) (a) A carrier offering a group health benefit plan in this state shall permit an employer to purchase a group health benefit plan at any point during the year.

(b) In the case of health benefit plans offered in the small group market, a carrier may decline to offer coverage to a small employer that is unable to comply with a material plan provision relating to employer contribution or group participation rules, as required by section 10-16-105 (3)(b), and that carrier may limit the availability of coverage for a group it has declined to an enrollment period that begins November 15 and ends December 15 of each year or begins and ends on dates set by the commissioner by rule.

(c) The coverage is effective consistent with the dates determined by the commissioner by rule.

(3) (a) (I) A carrier offering an individual health benefit plan in this state shall establish special enrollment periods during which an individual for whom a triggering event has occurred may enroll in an individual health benefit plan offered by the carrier.

(II) A triggering event occurs when:

(A) An individual involuntarily loses existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium;

(B) An individual gains a dependent or becomes a dependent through marriage, civil union, birth, adoption, or placement for adoption or by entering into a designated beneficiary agreement pursuant to article 22 of title 15, C.R.S.;

(C) An individual's enrollment or nonenrollment in a health benefit plan is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or exchange established pursuant to article 22 of this title;

(D) An individual adequately demonstrates to the commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual;

(E) The exchange established pursuant to article 22 of this title determines an individual to be newly eligible or newly ineligible for the federal advance payment tax credit or cost-sharing reductions available through the exchange pursuant to federal law;

(F) An individual gains access to other creditable coverage as a result of a permanent change of residence;

(F.5) An uninsured individual was included in the calculation of "family size" as defined in the federal "Internal Revenue Code of 1986", 26 U.S.C. sec. 36B (d)(1), as amended, by a tax filer who filed an income tax return for the prior calendar year by the April 15 tax deadline, and the exchange notifies the individual based on information provided through the Colorado affordable health care coverage easy enrollment program created in section 10-22-113 that the individual qualifies for a subsidized health benefit plan;

(G) Any other event or circumstance occurs as set forth in rules of the commissioner defining triggering events; or

(H) Beginning January 1, 2024, an individual who does not have existing creditable coverage receives certification from a health-care provider acting within the provider's scope of practice that the individual is pregnant. Coverage is deemed effective as of the first month in which the individual receives certification of the pregnancy, unless the individual elects to have coverage effective on the first day of the month following the date that the individual makes a plan selection. Any person or entity enrolling an individual in coverage pursuant to this special enrollment period shall provide a notice, developed by the department through a stakeholder process, to the individual regarding the individual's option to begin coverage either prospectively or retroactively and the financial and tax implications of those options. The notice must be in, at a minimum, English and Spanish.

(III) For the purposes of subsection (3)(a)(II)(F.5) of this section, a carrier is not required to further verify that an individual is eligible for a special enrollment period.

(b) (I) A carrier offering a group health benefit plan in this state shall establish special enrollment periods during which an individual for whom a qualifying event has occurred may enroll in a group health benefit plan offered by the carrier.

(II) A qualifying event occurs when:

(A) An individual loses coverage under a health benefit plan due to the death of a covered employee; the termination or reduction in number of hours of the covered employee's employment; or the covered employee becoming eligible for benefits under Title XVIII of the federal "Social Security Act", as amended;

(B) An individual loses coverage under a health benefit plan due to the divorce or legal separation of the covered employee from the covered employee's spouse or partner in a civil union;

(C) An individual becomes a dependent of a covered person through marriage, civil union, birth, adoption, or placement for adoption, by entering into a designated beneficiary agreement pursuant to article 22 of title 15, C.R.S., or pursuant to a court or administrative order mandating that the individual be covered;

(D) An individual loses other creditable coverage due to the termination of his or her employment or eligibility for the coverage; reduction in number of hours of employment;

involuntary termination of coverage; or reduction or elimination of his or her employer's contributions toward the coverage;

(E) An individual loses eligibility under the "Colorado Medical Assistance Act", articles 4 to 6 of title 25.5, C.R.S., or the children's basic health plan, article 8 of title 25.5, C.R.S.; or

(F) Any other event or circumstance occurs as set forth in rules of the commissioner defining qualifying events.

(c) The commissioner shall adopt rules in accordance with federal law for the implementation of this section. The commissioner may adopt rules to allow individuals enrolled in a health benefit plan through an exchange established under article 22 of this title to enroll in or change from one health benefit plan to another under circumstances specified in the rules.

Source: L. 2013: Entire section added, (HB 13-1266), ch. 217, p. 936, § 10, effective May 13. **L. 2020:** (3)(a)(II)(F) amended and (3)(a)(II)(F.5) and (3)(a)(III) added, (HB 20-1236), ch. 236, p. 1143, § 1, effective September 14. **L. 2022:** (3)(a)(II)(H) added, (HB 22-1289), ch. 399, p. 2835, § 4, effective June 7.

Cross references: For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

10-16-105.9. Health benefit plan - carrier insolvency - covered persons - deductible amounts - rules - definition. (1) As used in this section:

(a) "Out-of-pocket expenses" means expenses paid toward a health benefit plan:

(I) Deductible for medical services and prescription drugs that were credited under the covered person's health benefit plan; and

(II) Out-of-pocket maximum for medical services and prescription drugs that were credited under the person's health benefit plan, including any coinsurance amounts.

(b) "Out-of-pocket expenses" does not include premium payments made for a health benefit plan.

(2) For individual health benefit plans, if a covered person has paid any out-of-pocket expenses for services covered by a health benefit plan in a given plan year, and the carrier that provides the health benefit plan to the covered person exits the health insurance market and can no longer provide health insurance benefits to that person during the same plan year, a carrier of a new health benefit plan that covers the person during the same plan year shall credit all of the out-of-pocket expenses paid by the covered person to the new health benefit plan.

(3) If a covered person's out-of-pocket expenses credited to the new health benefit plan in accordance with subsection (2) of this section for coverage under the original health benefit plan are greater than the amount of out-of-pocket expenses required by the new health benefit plan, the new carrier is not required to apply the amount in excess to the new health benefit plan.

(4) The commissioner shall promulgate rules to implement this section that include protocols for each carrier to follow when crediting out-of-pocket expenses paid by a covered person to a new health benefit plan and protocols for the division to follow to ensure that the necessary data to determine the amount of the out-of-pocket expenses credit for each new member is delivered to each carrier in a timely and accurate manner by the commissioner. The commissioner shall collect the necessary data from the carriers for the division's determination of the amount of the out-of-pocket expense credits. The protocols must be based on the out-of-

pocket maximum amounts, as described in section 10-16-161, from the division. The commissioner shall consult with the exchange to develop the protocols.

(5) The new health benefit plan is required only to credit out-of-pocket expenses toward the deductible and the out-of-pocket maximum, which are reported by the previous health benefit plan, the health benefit plan's conservatorship, or the division in a time and manner determined by the commissioner.

(6) (a) The new carrier may file a claim for the amount of the credited out-of-pocket expenses as a result of this section with the estate of the original health benefit plan carrier.

(b) (I) A carrier may recoup, over a reasonable length of time, a sum equal to the amount of out-of-pocket expenses credited to covered persons, in accordance with this section. The amount must be reasonably calculated to recoup these expenses and is subject to review by the commissioner. An amount recouped is not considered a premium for any other purpose, including the computations of gross premium tax or an agent's commission.

(II) A carrier that imposes a surcharge to recoup the amount of out-of-pocket expenses credited pursuant to this section must include the amount of the surcharge as part of the carrier's rate filing pursuant to section 10-16-107 (1). The carrier must show the surcharge in the rate filing as a separate component of the rate and shall include supporting documentation.

(7) A carrier shall not file a claim for the amount of the increase in claims liability due to this section with the estate of the original health benefit plan if the carrier has recouped costs for out-of-pocket expenses credited to covered persons in accordance with subsection (6)(b) of this section.

(8) Subject to approval by the commissioner, a carrier is not required to credit all of the out-of-pocket expenses paid by the covered person to the new health benefit plan in accordance with subsection (2) of this section if doing so would cause the carrier to become insolvent.

Source: L. 2024: Entire section added, (HB 24-1258), ch. 335, p. 2272, § 1, effective January 1, 2025.

10-16-106. Group replacement - extension of benefits. (1) This section shall indicate which carrier is liable where one carrier's group contract replaces a plan of similar benefits of another carrier within thirty-one days after the termination, cancellation, or expiration of the contract that is being replaced.

(2) The prior carrier remains liable only to the extent of its accrued liabilities, extensions of benefits as specified in the policy contract, and benefits for covered persons until release from an in-patient facility as required by section 10-16-705 (4). The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes coverage.

(3) Liability of a succeeding carrier is as follows:

(a) Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits, with respect to classes eligible and actively at work and nonconfinement rules, if allowable, shall be covered by the succeeding carrier's plan of benefits except with respect to accrued liabilities and extensions of benefits provided for in subsection (2) of this section.

(b) Each person who is not eligible under the succeeding carrier's plan of benefits in accordance with paragraph (a) of this subsection (3) shall be covered by the succeeding carrier in accordance with the following guidelines if such individual was validly covered, including

benefit extension, under the prior plan on the date of discontinuance. Such guidelines are as follows:

(I) The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan.

(II) Coverage shall be provided by the succeeding carrier until at least the earliest of the following dates:

(A) The date the individual becomes eligible under the succeeding carrier's plan as described in paragraph (a) of this subsection (3);

(B) The date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage, where employment is terminated or where the individual ceases to be an eligible dependent.

(C) (Deleted by amendment, L. 99, p. 196, § 2, effective January 1, 2000.)

(III) Nothing in this paragraph (b) shall be construed to limit the duration of continuation coverage provided for in section 10-16-108.

(c) (Deleted by amendment, L. 99, p. 196, § 2, effective January 1, 2000.)

(d) Each person previously covered by a policy which included deductibles or waiting periods shall be given credit for the satisfaction or partial satisfaction of the same or similar provisions in the succeeding policy where it provides similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior carrier's plan during the ninety days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible provision.

(e) Where a determination of the extent of the prior carrier's benefits is required, the prior carrier shall furnish a statement of such benefits or other pertinent information sufficient to permit verification of the benefit determination or sufficient to allow the succeeding carrier to make the determination. For the purposes of this paragraph (e), benefits of the prior plan will be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage had not been replaced by the succeeding carrier.

Source: L. 92: Entire article R&RE, p. 1637, § 1, effective July 1. **L. 99:** (1), (2), (3)(a), (3)(b), and (3)(c) amended, p. 196, § 2, effective January 1, 2000.

Editor's note: The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

10-16-106.3. Uniform claims - billing codes - electronic claim forms. (1) On or before July 1, 2002, all carriers shall accept the claim form adopted by the American dental association for use by all dental providers and carriers in the state, and the federal centers for medicare and medicaid services' claim forms CMS-1500 and CMS-1450, otherwise known as form UB-04, as amended, as the uniform health-care claim forms for use by all other health-care providers and carriers in the state. All carriers shall accept such claim forms from health-care

providers in electronic form. A carrier shall not prohibit submission of health-care claims in hard copy form, nor shall a carrier be prohibited from requiring that a claim be submitted in hard copy form. A carrier shall not require submission of a claim on a form other than those set forth in this section, except as provided in subsection (3) of this section.

(2) On or before July 1, 2002, the commissioner shall adopt a uniform list of required elements to be used on the uniform claim forms accepted by carriers pursuant to this section. Such elements shall be used by health-care providers in order for a claim to be considered a clean claim.

(3) Concurrent with the effective date for implementation of the federal "Health Insurance Portability and Accountability Act of 1996", as amended, and the federal regulations implemented pursuant to such act, as amended, for claims filed electronically, carriers shall require the submission of electronic claims with the elements in the format required by such act and such regulations and shall not require the submission of forms and elements pursuant to subsections (1) and (2) of this section.

Source: L. 2002: Entire section added, p. 312, § 1, effective April 19. **L. 2007:** (1) amended, p. 921, § 1, effective May 17. **L. 2023:** (1) amended, (HB 23-1301), ch. 303, p. 1817, § 9, effective August 7.

10-16-106.5. Prompt payment of claims - legislative declaration - rules. (1) The general assembly finds, determines, and declares that:

(a) Patients and health-care providers often do not receive the reimbursements to which they are entitled from health insurance entities in a timely manner, even in the case of claims that are submitted on standard forms and do not require additional information for processing; and

(b) Unnecessary delays in the payment of routine and uncontested claims for reimbursement represent an unwarranted drain on health-care providers' resources, which could be better spent attending to the needs of patients, as well as wasting the time and money of the patients themselves. Therefore, it is in the interest of the citizens of Colorado that reasonable standards be imposed for the timely payment of claims.

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

(2.5) This section shall apply to claims made as a result of injuries sustained in a motor vehicle accident regardless of whether fault in such accident has been determined.

(2.7) (a) A policyholder, insured, or provider may submit a claim:

(I) By United States mail, first class, or by overnight delivery service;

(II) Electronically;

(III) By facsimile (fax); or

(IV) By hand delivery.

(b) (I) A carrier shall make a mechanism available to providers that shall enable a provider to confirm the receipt of a claim that is filed with the carrier in a manner other than

electronically. Within ten business days after the submission of the claim as determined by the provider, the carrier shall list such claim on the notification mechanism as received. The claim shall be deemed received on the date it is listed on the notification mechanism by the carrier. If a claim is not listed on the notification mechanism, the provider may contact the carrier for the purposes of resubmission of the claim. The carrier shall have a separate facsimile process to receive the resubmission of the paper claims. The resubmitted claim shall be deemed received on the date of the facsimile transmission acknowledgment. If such mechanism is accessible only by electronic means, upon request of the provider, the information must be made available in hard-copy form within three business days.

(II) If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the carrier or the carrier's clearinghouse. The carrier or carrier's clearinghouse shall provide a confirmation within one business day after submission by a provider.

(3) Every carrier shall provide a copy of its filing requirements to:

(a) Every enrollee or insured upon enrollment in the carrier's plan or upon issuance of the policy when applicable;

(b) Every enrollee or insured, upon request, within fifteen calendar days;

(c) Every participating provider upon acceptance of the provider into the carrier's network; and

(d) Every enrollee, insured, and participating provider within fifteen calendar days after any change in the standard form or the accompanying instructions or requirements when applicable.

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

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

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

(d) (I) Except as otherwise provided in paragraph (b) of this subsection (4), if the carrier intends to prospectively conduct a charge audit, such carrier shall, not later than the forty-fifth day after the date the carrier receives the claim, pay the charges submitted by any participating institutional provider at a rate of at least eighty-five percent of the contracted rate on the claim, less deductibles, coinsurance, and copayments, and shall pay a nonparticipating institutional provider at least sixty percent of the amount due on the claim, less deductibles, coinsurance, and

copayments. The carrier shall complete the charge audit, and make any additional payment not later than the ninetieth day after receipt of a claim.

(II) The institutional provider shall allow reasonable access to the records necessary to conduct the audit within the time period required by this paragraph (d).

(III) For the purposes of this paragraph (d), "charge audit" means an audit to determine whether data in an enrollee's medical record documents the health-care services listed on a claim for payment submitted to a carrier. "Charge audit" does not mean a review of the medical necessity of the services provided.

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

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health-care provider, with proper assignment, a penalty in an amount equal to twenty percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier. If a carrier denies a claim in accordance with subsection (4) of this section within ninety days after receiving the claim and the denial is determined to be unreasonable pursuant a civil action in accordance with section 10-3-1116, the carrier shall pay the penalty in this paragraph (b) to the insured or to the assignee.

(c) To the extent that penalties are not paid concurrently with the claim, the penalties in this section may be paid on a quarterly basis or when the aggregate penalties for a provider exceeds ten dollars.

(6) This section shall not prohibit a carrier from retroactively adjusting payment of a claim that is not subject to the provisions of section 10-16-704, if:

(a) The policyholder notifies the carrier of a change in eligibility of an individual; and

(b) The adjustment is made within thirty days after the carrier's receipt of such notification.

(7) If a carrier delegates its claims processing functions to a third party, the delegation agreement shall provide that the claims processing entity shall comply with the requirements of this section. Any delegation by the carrier shall not be construed to limit the carrier's responsibility to comply with this section or any other applicable section of this article.

(8) This section does not apply to a claim filed:

(a) Pursuant to the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S.; or

(b) For an individual entitled to a three-month grace period as described in section 10-16-140 (1), when the claim is for services rendered after the first month of the three-month grace period. The commissioner may adopt rules as necessary to implement and administer this paragraph (b).

(9) The commissioner may investigate claims against a health coverage plan that is authorized to conduct business in this state when such claims are filed by a provider related to the improper handling or denial of benefits pursuant to this section.

Source: L. 99: Entire section added, p. 1140, § 1, effective January 1, 2000. **L. 2002:** (2), (4)(b), and (5)(b) amended and (2.7), (4)(d), (5)(c), (7), and (8) added, pp. 313, 314, §§ 2, 3, effective April 19; (6) amended, p. 887, § 4, effective January 1, 2003. **L. 2003:** (9) added, p. 2494, § 1, effective June 5; (2.5) amended, p. 1572, § 7, effective July 1. **L. 2006:** (2.5) amended, p. 977, § 1, effective January 1, 2007. **L. 2008:** (5)(b) amended, p. 2174, § 7, effective August 5. **L. 2013:** (8) amended, (HB 13-1266), ch. 217, p. 939, § 11, effective May 13.

10-16-106.7. Assignment of health insurance benefits. (1) (a) Any carrier that provides health coverage to a covered person shall allow, but not require, such covered person under the policy to assign, in writing, payments due under the policy to a licensed hospital or other licensed health-care provider; an occupational therapist, as defined in section 12-270-104 (9); an occupational therapy assistant, as defined in section 12-270-104 (11); or a massage therapist, as defined in section 12-235-104 (5), also referred to in this section as the "provider", for services provided to the covered person that are covered under the policy.

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

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

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

(c) If the provider collects payment from the enrollee and subsequently receives payment from the carrier, the provider shall reimburse the enrollee, less any applicable copayments, deductibles, or coinsurance amounts, within forty-five days.

(3) Nothing in this section shall be construed to limit a carrier's ability to determine the scope of its benefits, services, or any other terms of its policies, or from negotiating contracts with licensed hospitals or other licensed health-care providers on reimbursement rates or any other lawful provisions.

Source: L. 2005: Entire section added, p. 489, § 1, effective August 8. **L. 2008:** (1)(a) amended, p. 830, § 7, effective July 1. **L. 2009:** (1)(a) amended, (SB 09-292), ch. 369, p. 1945, § 18, effective August 5. **L. 2010:** (1)(a) amended, (HB 10-1220), ch. 197, p. 856, § 23, effective July 1. **L. 2019:** (1)(a) amended, (HB 19-1172), ch. 136, p. 1654, § 43, effective October 1. **L. 2021:** (1)(a) amended, (SB 21-003), ch. 4, p. 28, § 5, effective January 21.

10-16-107. Rate filing regulation - benefits ratio - rules. (1) (a) A carrier subject to part 2, 3, 4, or 5 of this article 16 shall not establish rates for any sickness, accident, or health insurance policy, contract, certificate, or other evidence of coverage or dental coverage plan, as defined in section 10-16-165 (1)(b), issued or delivered to any policyholder, enrollee, subscriber, or member in Colorado that are excessive, inadequate, or unfairly discriminatory. To assure compliance with the requirements of this section that rates are not excessive in relation to benefits, the commissioner shall promulgate rules to require rate filings and, as part of the rules, may require the submission of adequate documentation and supporting information, including actuarial opinions or certifications and set expected benefits ratios. The carrier shall submit expected rate increases to the commissioner at least sixty days prior to the proposed implementation of the rates. If the commissioner does not approve or disapprove the rate filings within a sixty-day period, the carrier may implement and reasonably rely upon the rates on the condition that the commissioner may require correction of any deficiencies in the rate filing upon later review if the rate the carrier charged is excessive, inadequate, or unfairly discriminatory. A prospective rate adjustment is the sole remedy for rate deficiencies pursuant to this subsection (1). If the commissioner finds deficiencies in the rate filing after a sixty-day period, the commissioner shall provide notice to the carrier, and the carrier shall correct the rate on a prospective basis.

(b) The commissioner may review expected rate filing increases filed with the commissioner and shall disapprove the rate increase and require the carrier to resubmit for approval if any of the provisions of subsection (3) of this section apply. Rate filings that do not involve a requested rate increase, or that involve a requested rate increase of less than five percent for dental insurance, do not require preapproval, and the carrier may implement the rate upon filing with the commissioner.

(c) The filing requirements of this subsection (1) do not apply to nondeveloped rates, including rates for medicaid, medicare, and the children's basic health plan, as defined by the commissioner.

(d) If the carrier fails to supply the information required by this section, the filing is incomplete. The commissioner shall make a determination of completeness no later than thirty days following submission of the filing for review. All filings not returned on or before the thirtieth day after receipt are considered complete.

(e) The commissioner may review filings for substantive content and, if reviewed, shall identify and communicate to the filing carrier, on or before the forty-fifth day after receipt, any deficiency in the filing. The carrier shall apply a correction of a deficiency, including a deficiency identified after the forty-fifth day, on a prospective basis, and the commissioner shall not assess a penalty against the carrier if the violation identified was not willful.

(f) Carriers shall file rate filings for insurance regulated under parts 1 to 5 of this article 16 electronically in a format made available by the division, unless exempted by rule for an emergency situation as determined by the commissioner. The division shall post on its website a rate filing summary for insurance regulated under parts 1 to 5 of this article 16 in order to provide notice to the public.

(g) This section does not:

(I) Limit the right of the public to inspect a rate filing and any supporting information pursuant to part 2 of article 72 of title 24, C.R.S.; or

(II) Impair the commissioner's ability to review rates and determine whether the rates are excessive, inadequate, or unfairly discriminatory.

(2) (a) (I) Rates for an individual health coverage plan issued or delivered to any policyholder, enrollee, subscriber, or member in Colorado by an insurer subject to part 2 of this article 16 or an entity subject to part 3, 4, or 5 of this article 16 shall not be excessive, inadequate, or unfairly discriminatory to assure compliance with the requirements of this section that rates are not excessive in relation to benefits. Rates are excessive if they are likely to produce a long run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered. In determining if rates are excessive, the commissioner may consider:

(A) The expected filed rates in relation to the actual rates charged;

(B) Whether the carrier's products are affordable; and

(C) Whether the carrier has implemented effective strategies to enhance the affordability of its products.

(II) Rates are not inadequate unless clearly insufficient to sustain projected losses and expenses, or the use of the rates, if continued, will tend to create a monopoly in the market.

(III) Rates are unfairly discriminatory if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses.

(b) Notwithstanding any other provision of this article 16, a carrier subject to part 2, 3, 4, or 5 of this article 16 shall not vary the premium rate for an individual health coverage plan due to the gender of the individual policyholder, enrollee, subscriber, or member. Any premium rate based on the gender of the individual policyholder, enrollee, subscriber, or member is unfairly discriminatory and is not allowed.

(3) (a) The commissioner shall disapprove the requested rate increase if any of the following apply:

(I) The benefits provided are not reasonable in relation to the premiums charged;

(II) The requested rate increase contains a provision or provisions that are excessive, inadequate, unfairly discriminatory, or otherwise do not comply with the provisions of this title;

(III) The requested rate increase is excessive or inadequate. In determining if the rate is excessive or inadequate, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve and reserve for losses, surpluses, executive salaries, expected benefits ratios, any factors in section 10-16-111, and any other appropriate actuarial factors as determined by current actuarial standards of practice.

(IV) The actuarial reasons and data based upon Colorado claims experience and data, when available, do not justify the necessity for the requested rate increase;

(V) The rate filing is incomplete;

(VI) The rate filing fails to demonstrate compliance with the MHPAEA. The commissioner shall adopt rules to establish the process and timeline for carriers to demonstrate compliance with the MHPAEA in establishing their rates.

(VII) The rate filing reflects a cost shift between the standardized plan, as defined in section 10-16-1303 (14), offered by the carrier and the health benefit plan for which rate approval is being sought. The commissioner may consider the total cost of health care in making this determination.

(b) In determining whether to approve or disapprove a rate filing, the commissioner may consider, without limitation, the expected benefits ratio for a health benefit plan or any other cost category determined appropriate by the commissioner. If the carrier achieves a benefits ratio of eighty-five percent or higher for large group insurance, eighty percent for small group insurance, and eighty percent for individual insurance, the commissioner may expedite the review of the approval process for the carrier.

(c) The commissioner shall adopt rules that establish the benefits ratio for carriers to use for rate filing purposes for health benefit plans, other than grandfathered health benefit plans. The rules must include, as supplemental criteria that will be considered during review, requirements for carriers to provide information on activities to improve health-care quality as set forth under the authority of section 2718 of the federal "Public Health Service Act", as amended, and in 45 CFR 158.150 and expenditures related to health information technology and meaningful use as set forth in 45 CFR 158.151.

(3.5) The commissioner shall promulgate rules establishing affordability standards. These standards must include appropriate targets for carrier investments in primary care. In developing these standards, the commissioner shall consider the recommendations of the primary care payment reform collaborative created in section 10-16-150.

(4) The commissioner may require the submission of any relevant information the commissioner deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(5) (a) (I) With respect to the premium rates charged by a carrier offering an individual or small employer health benefit plan, the carrier shall develop its premium rates based on, and vary the premium rates with respect to the particular plan or coverage only by the following case characteristics:

(A) Whether the plan or coverage covers an individual or family;

(B) Geographic rating area, established in accordance with federal law;

(C) Age, except that the rate must not vary by more than three to one for adults; and

(D) Tobacco use, except that the rate must not vary by more than one and one-fifteenth to one.

(II) The carrier shall not vary a premium rate with respect to any particular individual or small employer health benefit plan by any factor other than the factors described in subparagraph (I) of this paragraph (a).

(III) With respect to family coverage under an individual or small employer health benefit plan, the carrier shall apply the rating variations permitted under sub-subparagraphs (C) and (D) of subparagraph (I) of this paragraph (a) based on the portion of the premium that is attributable to each family member covered under the plan in accordance with rules of the commissioner.

(b) The carrier shall not adjust the premium charged with respect to any particular individual or small employer health benefit plan more frequently than annually; except that the carrier may change the premium rates to reflect:

(I) With respect to a small employer health benefit plan, changes to the enrollment of the small employer;

(II) Changes to the family composition of the policyholder or employee;

(III) With respect to an individual health benefit plan, changes in geographic rating area of the policyholder, as provided in sub-subparagraph (B) of subparagraph (I) of paragraph (a) of this subsection (5);

(IV) Changes in tobacco use, as provided in sub-subparagraph (D) of subparagraph (I) of paragraph (a) of this subsection (5);

(V) Changes to the health benefit plan requested by the policyholder or small employer; or

(VI) Other changes required by federal law or regulations or otherwise expressly permitted by state law or commissioner rule.

(c) (I) A carrier shall consider all individuals in all individual health benefit plans, other than grandfathered health benefit plans, offered by the carrier, including those individuals who do not enroll in the plans through an exchange established under article 22 of this title, to be members of a single risk pool.

(II) A carrier shall consider all covered persons in all small employer health benefit plans, other than grandfathered health benefit plans, offered by the carrier, including those covered persons who do not enroll in the plans through an exchange established under article 22 of this title, to be members of a single risk pool.

(d) Any individual who does not qualify for a lower rate based on tobacco use may be offered the option of participating in a bona fide wellness program, as defined under the federal "Health Insurance Portability and Accountability Act of 1996", as amended. A carrier may allow any individual who participates in a bona fide wellness program the lower rate. The carrier shall disclose the availability of a tobacco rating adjustment and any bona fide wellness program to each potential insured. The provisions of this paragraph (d) are applicable only if allowed under federal law.

(e) The commissioner may adopt rules to implement and administer this subsection (5) and to assure that rating practices used by carriers are consistent with the purposes of this article.

(f) A carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(I) How premium rates are established;

(II) The provisions of the coverage concerning the carrier's right to change premium rates, the factors that may affect changes in premium rates, and the frequency with which the carrier may change premium rates; and

(III) (A) With respect to individual health benefit plans, a listing of and descriptive information about, including benefits and premiums, all individual health benefit plans offered by the carrier and the availability of the plans for which the individual is qualified; and

(B) With respect to small employer health benefit plans, a listing of and descriptive information about, including benefits and premiums, all small employer health benefit plans for which the small employer is qualified.

(g) (I) Each carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(II) Each carrier shall annually file with the commissioner, on or before March 15, an actuarial certification certifying that the carrier is in compliance with this article and that the rating methods of the carrier are actuarially sound. The certification must be in a form and

manner and must contain information as specified by the commissioner. The carrier shall retain a copy of the certification at its principal place of business.

(III) (A) A carrier shall make the information and documentation described in subparagraph (I) of this paragraph (g) available to the commissioner upon request.

(B) Except in cases of violations of this section, the information is considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(6) (a) The carrier shall use the applicable index rate for the premium rate for all of the carrier's individual and small group health benefit plans and shall adjust the applicable index rate for total expected market-wide payments and charges under the risk adjustment and reinsurance programs in the state, subject only to the adjustments permitted in federal and state law. The commissioner may establish, by rule, the components and adjustments that carriers are able to use and make to the index rate.

(b) A carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(c) For the purposes of this subsection (6), a health benefit plan that contains a restricted network provision is not similar coverage to a health benefit plan that does not contain a restricted network provision if the restriction of benefits to network providers results in substantial differences in claim costs.

(7) Starting in 2021, as part of the rate filing required pursuant to this section, each carrier shall provide to the commissioner, in a form and manner determined by the commissioner, information concerning the utilization of out-of-network providers and facilities and the aggregate cost savings as a result of the implementation of section 10-16-704 (3)(d)(I) and (5.5)(b)(I).

(8) (a) The commissioner may adopt rules designed to:

(I) Maximize the purchasing power of exchange consumers whose household income is up to four hundred percent of the federal poverty line; and

(II) Assure premium pricing that complies with the requirements in the federal act for modified community rating.

(b) In adopting these rules, the commissioner may consider the results of the evaluation and study of the reinsurance program conducted pursuant to section 10-16-1104 (2).

Source: L. 92: Entire article R&RE, p. 1639, § 1, effective July 1; (1) amended and (1.5) and (1.7) added, p. 1774, § 2, effective July 1; (2), (3)(a), and (3)(f) amended, p. 1744, § 4, effective January 1, 1993. **L. 94:** (3)(d) amended, p. 1629, § 26, effective May 31. **L. 96:** (5) added, p. 730, § 2, effective July 1. **L. 97:** (2) and (3)(e) amended, p. 530, § 2, effective April 24; (7) added, p. 416, § 1, effective April 24; (6) added, p. 639, § 6, effective May 1. **L. 98:** (5)(a) and IP(5)(b)(I) amended, p. 124, § 1, effective January 1, 1999. **L. 99:** (3)(b)(II)(A) amended, p. 320, § 5, effective July 1; (3)(e)(I) amended, p. 84, § 6, effective July 1. **L. 2000:** (5.5) added, p. 195, § 1, effective March 27. **L. 2001:** (1.5)(b) amended, p. 1214, § 42, effective January 1, 2002. **L. 2004:** (8) added, p. 963, § 1, effective May 21. **L. 2005:** (1.5)(f) amended, p. 762, § 15, effective June 1. **L. 2007:** (1), (1.5)(c), and (3)(e)(I) amended, p. 2004, § 2, effective January 1, 2008. **L. 2008:** (1) amended, p. 2250, § 5, effective June 5; (1.5), (1.7), and (3)(e) amended and (1.6) added, p. 2251, § 6, effective July 1. **L. 2009:** (6) amended, (HB 09-1012), ch. 188, p. 823,

§ 2, effective July 1. **L. 2010:** (6) amended, (HB 10-1160), ch. 283, p. 1327, § 4, effective July 1; (1.5) amended, (HB 10-1008), ch. 40, p. 162, § 1, effective January 1, 2011. **L. 2013:** Entire section amended with relocations, (HB 13-1266), ch. 217, p. 939, § 12, effective May 13. **L. 2019:** (2)(a)(I) amended and (3.5) added, (HB 19-1233), ch. 194, p. 2122, § 4, effective May 16; (3)(a)(IV) and (3)(a)(V) amended and (3)(a)(VI) added, (HB 19-1269), ch. 195, p. 2128, § 5, effective May 16; (7) added, (HB 19-1174), ch. 171, p. 1982, § 3, effective January 1, 2020. **L. 2020:** (8) added, (SB 20-215), ch. 201, p. 997, § 2, effective June 30. **L. 2021:** (3)(a)(V) amended and (3)(a)(VII) added, (HB 21-1232), ch. 241, p. 1293, § 2, effective June 16. **L. 2023:** (1)(a), (1)(f), IP(2)(a)(I), and (2)(b) amended, (SB 23-179), ch. 332, p. 1989, § 2, effective August 7.

Editor's note: (1) (a) The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

(b) Subsections (6)(b) and (6)(c) are similar to former § 10-16-105 (8)(c)(II) and (8)(d), respectively, as they existed prior to 2013.

(c) In 2013, former subsections (3)(b), (3)(c), and (3)(d) were relocated to § 10-16-406 (2); former subsection (5)(a) was relocated to § 10-16-139 (1); former subsection (5.5) was relocated to § 10-16-139 (2); former subsection (6) was relocated to § 10-16-105.6 (1); and former subsection (7) was relocated to § 10-16-139 (3).

Cross references: (1) For the federal "Public Health Service Act", see 42 U.S.C. § 201 et seq., and for section 2718 of that act, see 42 U.S.C. § 300gg-18.

(2) For the legislative declaration contained in the 1992 act amending subsection (1) and enacting subsections (1.5) and (1.7), see section 1 of chapter 218, Session Laws of Colorado 1992. For the legislative declaration contained in the 1997 act enacting subsection (6), see section 1 of chapter 154, Session Laws of Colorado 1997. For the legislative declaration contained in the 1999 act amending subsection (3)(b)(II)(A), see section 1 of chapter 111, Session Laws of Colorado 1999. In 2008, subsections (1), (1.5), (1.7), and (3)(e) were amended and subsection (1.6) was enacted by the "Fair Accountable Insurance Rates Act". For the short title and legislative declaration, see sections 1 and 2 of chapter 439, Session Laws of Colorado 2008. For the legislative declaration in HB 19-1233, see section 1 of chapter 194, Session Laws of Colorado 2019. For the legislative declaration in SB 23-179, see section 1 of chapter 332, Session Laws of Colorado 2023.

(3) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

10-16-107.1. False or misleading information - penalties. (1) A person or organization shall not knowingly withhold information that will affect the rates or premiums chargeable under this part 1 or knowingly give false or misleading information to the commissioner or any statistical agent, advisory organization, or carrier. A person or organization who violates this section shall be subject to the penalties in subsection (2) of this section.

(2) Upon a finding that any person or organization has knowingly violated subsection (1) of this section, the commissioner may impose a penalty of not more than ten thousand dollars for each violation but, if the violation is found to be willful, a penalty of not more than twenty-five

thousand dollars for each violation. The penalties may be in addition to any other penalty provided by law.

Source: L. 2008: Entire section added, p. 2255, § 7, effective July 1.

Cross references: In 2008, this section was enacted by the "Fair Accountable Insurance Rates Act". For the short title and legislative declaration, see sections 1 and 2 of chapter 439, Session Laws of Colorado 2008.

10-16-107.2. Filing of health policies - rules. (1) All carriers authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. Each carrier shall submit the annual report by December 31 of each year and shall include in the report a certification by an officer of the carrier that, to the best of the carrier's good-faith knowledge and belief, each policy form, endorsement, or rider in use complies with Colorado law. The commissioner shall determine the necessary elements of the certification.

(2) All carriers authorized by the commissioner to conduct business in Colorado shall also submit to the commissioner a list of any new policy form, application, endorsement, or rider at least thirty-one days before using the policy form, application, endorsement, or rider for any health coverage. The carrier shall include in the listing a certification by an officer of the carrier that each new policy form, application, endorsement, or rider proposed to be used complies, to the best of the carrier's good-faith knowledge and belief, with Colorado law. The commissioner shall determine the necessary elements of the certification. A carrier shall not deliver or issue a new policy form, application, endorsement, or rider until the carrier files the listing and certification required by this subsection (2).

(3) The commissioner shall promulgate rules, as needed, setting forth the standards for policy forms, endorsements, and riders marketed in Colorado.

(4) The commissioner may examine and investigate carriers authorized to conduct business in Colorado to determine whether policy forms, endorsements, and riders comply with the certification of the carrier and statutory mandates.

Source: L. 92: Entire section added, p. 1745, § 5, effective June 2. **L. 2005:** (2) amended, p. 741, § 1, effective January 1, 2006. **L. 2006:** (2)(b)(I) amended, p. 1077, § 5, effective January 1, 2007. **L. 2010:** (2)(c) added, (HB 10-1242), ch. 222, p. 966, § 1, effective August 11. **L. 2013:** Entire section amended, (HB 13-1266), ch. 217, p. 950, § 13, effective May 13.

Editor's note: (1) Although the effective date for the repeal and reenactment of this article was July 1, 1992, this section was added, effective June 2, 1992.

(2) The former subsection (2)(b) was relocated to § 10-16-107.5 in 2013.

Cross references: For the legislative declaration contained in the 2006 act amending subsection (2)(b)(I), see section 1 of chapter 236, Session Laws of Colorado 2006.

10-16-107.3. Health insurance policies - plain language required - rules. (1) (a) A carrier issuing or renewing a health benefit plan, limited benefit health insurance, dental plan, or long-term care plan subject to this article shall not issue or renew the plan unless the text of the plan does not exceed the tenth-grade level as measured by the Flesch-Kincaid grade level formula or does not score less than fifty as measured by the Flesch reading ease formula.

(b) In conjunction with the report submitted to the commissioner pursuant to section 10-16-107.2, the carrier shall report the readability scores prior to the issuance or renewal of a policy or the use of the plan.

(2) The health benefit plan, limited benefit health insurance, dental plan, or long-term care plan shall contain an index or table of contents if the plan is more than three pages in length or if the text of the plan exceeds three thousand words. The index, table of contents, and text of the plan shall be printed in not less than ten-point type.

(3) For purposes of subsections (1) and (2) of this section, the following shall apply:

(a) (I) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall count as one word;

(II) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and

(III) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciations containing fewer syllables may be used.

(b) "Text" includes all printed matter except the following:

(I) The name and address of the carrier; the name, number, or title of the policy; the table of contents or index; captions and subcaptions; and specification pages, schedules, or tables; and

(II) Any policy language that is drafted to conform to the requirements of any federal law or regulation; any policy language required by any collectively bargained agreement; any medical terminology; any words that are defined in the policy; and any policy language required by law or regulation if the carrier identifies the language or terminology excepted and certifies in writing that the language or terminology is entitled to be excepted.

(4) The commissioner shall promulgate rules regarding the electronic dissemination of newly issued or renewed policy forms or endorsements.

(5) For the purposes of subsection (1) of this section, for group health benefit plans, the evidence of coverage or certificate of coverage that is provided to the covered person shall be the only text for the purposes of the Flesch-Kincaid grade level formula and the Flesch reading ease formula.

Source: L. 2010: Entire section added, (HB 10-1166), ch. 143, p. 487, § 2, effective January 1, 2012. **L. 2013:** IP(3) amended, (HB 13-1300), ch. 316, p. 1666, § 15, effective August 7.

10-16-107.4. Health-care sharing plan or arrangement - required reporting and certification - noncompliance - information posted on division website - rules. (1) A person

not authorized by the commissioner pursuant to article 3 of this title 10 to offer insurance in this state that offers or intends to offer a plan or arrangement to facilitate payment or reimbursement of health-care costs or services for residents of this state, regardless of whether the person is domiciled in this state or another state, shall submit to the commissioner by October 1, 2022, and by March 1 each year thereafter:

(a) The following information:

(I) The total number of individuals and households that participated in the plan or arrangement in this state in the immediately preceding calendar year;

(II) The total number of employer groups that participated in the plan or arrangement in this state in the immediately preceding calendar year, specifying the total number of participating individuals in each participating employer group;

(III) If the person offers a plan or arrangement in other states, the total number of participants in the plan or arrangement nationally;

(IV) Any contracts the person has entered into with providers in this state that provide health-care services to plan or arrangement participants;

(V) The total amount of fees, dues, or other payments collected by the person in the immediately preceding calendar year from individuals, employer groups, or others who participated in the plan or arrangement in this state, specifying the percentage of fees, dues, or other payments retained by the person for administrative expenses;

(VI) The total dollar amount of requests for reimbursement of health-care costs or services submitted in this state in the immediately preceding calendar year by participants in the plan or arrangement or providers that provided health-care services to plan or arrangement participants;

(VII) The total dollar amount of requests for reimbursement of health-care costs or services that were submitted in this state and were determined to qualify for reimbursement under the plan or arrangement in the immediately preceding calendar year;

(VIII) The total amount of payments made to providers in this state in the immediately preceding calendar year for health-care services provided to or received by a plan or arrangement participant;

(IX) The total amount of reimbursements made to plan or arrangement participants in this state in the immediately preceding calendar year for health-care services provided to or received by a plan or arrangement participant;

(X) The total number of requests for reimbursement of health-care costs or services submitted in this state in the immediately preceding calendar year that were denied, expressed as a percentage of total reimbursement requests submitted in that calendar year, and the total number of reimbursement request denials that were appealed;

(XI) The total amount of health-care expenses submitted in this state by plan or arrangement participants or providers in the immediately preceding calendar year that qualify for reimbursement pursuant to the plan or arrangement criteria but that, as of the end of that calendar year, have not been reimbursed, excluding any amounts that the plan or arrangement participants incurring the health-care costs must pay before receiving reimbursement under the plan or arrangement;

(XII) The estimated number of plan or arrangement participants the person is anticipating in this state in the next calendar year, specifying the estimated number of individuals, households, employer groups, and employees;

(XIII) The specific counties in this state in which the person:

(A) Offered a plan or arrangement in the immediately preceding calendar year; and

(B) Intends to offer a plan or arrangement in the next calendar year;

(XIV) Other states in which the person offers a plan or arrangement;

(XV) A list of any third parties, other than a producer, that are associated with or assist the person in offering or enrolling participants in this state in the plan or arrangement, copies of any training materials provided to a third party, and a detailed accounting of any commissions or other fees or remuneration paid to a third party in the immediately preceding calendar year for:

(A) Marketing, promoting, or enrolling participants in a plan or arrangement offered by the person in this state; or

(B) Operating, managing, or administering a plan or arrangement offered by the person in this state;

(XVI) The total number of producers that are associated with or assist the person in offering or enrolling participants in this state in the plan or arrangement, the total number of participants enrolled in the plan or arrangement through a producer, copies of any training materials provided to a producer, and a detailed accounting of any commissions or other fees or remuneration paid to a producer in the immediately preceding calendar year for marketing, promoting, or enrolling participants in a plan or arrangement offered by the person in this state;

(XVII) Copies of any consumer-facing and marketing materials used in this state in promoting the person's plan or arrangement, including plan or arrangement and benefit descriptions and other materials that explain the plan or arrangement;

(XVIII) The name, mailing address, email address, and telephone number of an individual serving as a contact person for the person in this state;

(XIX) A list of any parent companies, subsidiaries, and other names that the person has operated under at any time within the immediately preceding five calendar years; and

(XX) An organizational chart for the person and a list of the officers and directors of the person;

(b) A certification by an officer of the person that, to the best of the person's good-faith knowledge and belief, the information submitted is accurate and satisfies the requirements of this subsection (1).

(2) (a) If the person subject to the requirements of subsection (1) of this section fails to submit the information or certification required by said subsection, the submission is incomplete. The commissioner shall make a determination of completeness no later than forty-five days after the submission. If the commissioner has not informed the person of any deficiencies in the submission within forty-five days after receiving the submission, the submission is considered complete.

(b) (I) If the commissioner determines that a person fails to comply with the requirements of subsection (1) of this section, the commissioner shall:

(A) Notify the person that the submission is incomplete and enumerate in the notification each deficiency found in the person's submission; and

(B) Allow the person thirty days after notice of the incomplete submission to remedy the deficiency found in the submission.

(II) If the person does not remedy the deficiency within the thirty-day period, the commissioner may levy a fine not to exceed five thousand dollars per day.

(III) If the person does not remedy the deficiency or deficiencies within thirty days after the initial fine is levied, the commissioner may issue a cease-and-desist order in accordance with section 10-3-904.5.

(3) On or before April 1, 2023, and on or before each October 1 thereafter, the commissioner shall:

(a) Prepare a written report summarizing the information submitted by persons pursuant to subsection (1) of this section; and

(b) Post on the division's website the report and accurate and evidence-based information about the persons who submitted information pursuant to subsection (1) of this section, including how consumers may file complaints.

(4) The commissioner may adopt rules as necessary to implement this section.

(5) This section does not apply to:

(a) Direct primary care agreements as defined in article 23 of title 6; or

(b) Other consumer payment arrangements identified by the commissioner by rule, including consumer payment plans offered directly by a provider to a patient or the party responsible for payment on behalf of the patient.

Source: L. 2022: Entire section added, (HB 22-1269), ch. 444, p. 3125, § 1, effective June 8.

10-16-107.5. Uniform application form - use by all carriers - rules. (1) The commissioner, by rule, shall develop a uniform application form for health benefit plans and shall require all carriers providing health benefit plans that are authorized by the commissioner to conduct business in Colorado to exclusively use the uniform application form for the conduct of business in this state. By a date specified by the commissioner, all carriers that provide health benefit plans shall use the uniform application form for their health benefit plans.

(2) The commissioner may permit carriers to use a modified electronic version of the uniform application form.

Source: L. 2013: Entire section added with relocations, (HB 13-1266), ch. 217, p. 951, § 14, effective May 13.

Editor's note: This section is similar to former § 10-16-107.2 (2)(b) as it existed prior to 2013.

10-16-107.7. Nondiscrimination against providers. (1) A carrier offering an individual or group health benefit plan in this state shall not discriminate with respect to participation under the plan or coverage against any provider who is acting within the scope of his or her license or certification under applicable state law.

(2) This section does not:

(a) Require a carrier to contract with any provider willing to abide by the terms and conditions for participation established by the plan or carrier; or

(b) Prevent a carrier from establishing varying reimbursement rates based on quality or performance measures.

Source: L. 2013: Entire section added, (HB 13-1266), ch. 217, p. 952, § 15, effective May 13.

10-16-108. Continuation privileges. (1) **Group health benefit plans.** (a) Every employer group health benefit plan issued by a carrier must contain a provision specifying that if a covered employee's employment is terminated and the health benefit plan remains in force for active employees of the employer, the covered employee whose employment is terminated may elect to continue the coverage for himself or herself and his or her dependents. The provision must conform to the requirements, where applicable, of paragraphs (b), (c), and (e) of this subsection (1).

(b) An employee is eligible to make the election described in paragraph (a) of this subsection (1) on the employee's own behalf and on behalf of eligible, covered dependents if:

(I) The employee's eligibility to receive insurance coverage has ended for any reason other than discontinuance of the group policy in its entirety or with respect to an insured class;

(II) Any premium or contribution required from or on behalf of the employee has been paid through the employment termination date; and

(III) The employee has been continuously covered under the group health benefit plan, or under any group health benefit plan providing similar benefits that it replaces, for at least six months immediately prior to termination.

(c) The employer is not required to offer continuation of coverage to any person if the person is covered by medicare, Title XVIII of the federal "Social Security Act", or medicaid, Title XIX of the federal "Social Security Act".

(d) Once payment of disability benefits has started, a carrier shall not reduce benefits due under a policy of insurance insuring against disability from sickness or accident based on an increase in federal social security benefits.

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

(II) The employer shall notify the employee in writing of the employee's right to continue health-care coverage upon termination from employment. A written communication signed by the employee or a notice postmarked within ten days after termination mailed by the employer to the last-known address of the employee satisfies the notice requirements of this subparagraph (II). The notification must inform the employee of:

(A) The employee's right to elect to continue the existing coverage at the applicable rate;

(B) The amount the employee must pay monthly to the employer to retain the coverage, which payment includes the employer's contribution for the employee in addition to the employee's own contribution;

(C) The manner in which, and the office of the employer to which, the employee must submit the payment to the employer;

(D) The date and time by which the employee must submit the payments to the employer to retain coverage; and

(E) The fact that the employee will lose the coverage if the employee does not timely submit the payment to the employer.

(III) The employee shall notify the employer in writing of the employee's election to continue coverage and shall make proper payment to the employer as soon as possible upon notification by the employer of termination. In no case shall the employee submit the notification of election or the proper payment more than thirty days after the date of termination of employment unless the employer has failed to give timely notice in accordance with subparagraph (II) of this paragraph (e). If the employee timely submits the required payment and notice, the employee's health-care coverage is continued as if there had been no interruption of coverage. If the employee fails to timely submit proper payment and notice, the employer is relieved of any responsibility to the employee for the continuation of health-care coverage.

(IV) If the employer fails to notify an eligible employee of the right to elect to continue the coverage, the employee has the option to retain coverage if, within sixty days after the date the employment is terminated, the employee makes the proper payment to the employer to provide continuous coverage.

(V) After timely receipt of the monthly payment from an eligible employee, if the employer fails to make the payment to the carrier, with the result that the employee's coverage is terminated, the employer is liable for the employee's coverage, but to no greater extent than the amount of the premium.

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

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

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

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

Source: L. 92: Entire article R&RE, p. 1643, § 1, effective July 1; (1)(e)(I) and (2)(c)(I) amended, p. 1746, § 6, effective January 1, 1993. **L. 94:** (1)(a), IP(1)(c)(I), (1)(d)(I), (1)(e)(I), and (2)(c)(I) amended and (4) added, p. 1911, § 8, effective July 1; (1)(d)(II) to (1)(d)(VII), (1)(d)(XI), and (1)(d)(XII) repealed, p. 1920, § 14, effective July 1. **L. 99:** IP(1)(e)(II), (1)(e)(III), (1)(e)(IV), IP(2)(c)(II), (2)(c)(III), and (2)(c)(IV) amended, p. 198, §§ 3, 4, effective

January 1, 2000. **L. 2008:** (3) amended, p. 1232, § 1, effective May 27. **L. 2013:** Entire section R&RE, (HB 13-1266), ch. 217, p. 952, § 16, effective May 13.

Editor's note: The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

10-16-108.3. Continuation privileges - special election period - notice requirements - definitions - repeal. (Repealed)

Source: L. 2009: Entire section added, (HB 09-1349), ch. 377, p. 2049, § 1, effective June 1.

Editor's note: Subsection (10) provided for the repeal of this section, effective January 1, 2010. (See L. 2009, p. 2049.)

10-16-108.5. Fair marketing standards - rules. (1) Each carrier offering individual or small employer health benefit plans shall actively market health benefit plan coverage to eligible individuals or small employers in the state, as applicable.

(2) (a) Except as provided in paragraph (b) of this subsection (2), no carrier or producer shall, directly or indirectly, engage in the following activities:

(I) Encouraging or directing individuals or small employers to refrain from filing an application for coverage with the individual or small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the individual or small employer;

(II) Encouraging or directing individuals or small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the individual or small employer.

(b) The provisions of paragraph (a) of this subsection (2) shall not apply with respect to information provided by a carrier or producer to an individual or a small employer regarding the established geographic service area or a restricted network provision of a carrier.

(3) (a) Except as provided in paragraph (b) of this subsection (3), a carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual or small employer.

(b) Paragraph (a) of this subsection (3) shall not apply to a compensation arrangement with a producer on the basis of a percentage of premium if such percentage does not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual or small employer.

(4) Repealed.

(5) A carrier shall not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic area of the individuals or small employers placed by the producer with the carrier.

(6) No carrier shall induce or otherwise encourage a small employer to exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Any denial by a carrier of an application for coverage from an individual or a small employer shall be in writing and shall state any reason for the denial.

(8) The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to individuals and small employers in this state.

(9) A violation of this section by a carrier or a producer is an unfair or deceptive act or practice pursuant to the provisions of part 11 of article 3 of this title.

(10) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative marketing or other service related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

(11) (a) Effective January 1, 2014, all carriers offering or providing health benefit plan coverage shall provide a summary of benefits and coverage form that complies with the requirements of federal law. The commissioner shall adopt rules specifying when carriers are required to provide the form.

(b) (I) To the extent consistent with the summary of benefits and coverage form requirements in federal law, and in addition to the summary of benefits and coverage form required by paragraph (a) of this subsection (11), the commissioner may adopt and require carriers to provide any supplemental health benefit plan description forms the commissioner deems appropriate. The commissioner, by rule, may determine the format for and elements of the supplemental health benefit plan description form.

(II) The commissioner shall design the supplemental health benefit plan description form to facilitate the comparison of different health benefit plans. The form must also include informational materials specifying the plan's cancer screening coverages and their respective parameters.

(III) A carrier shall provide a completed supplemental health benefit plan description form when the carrier provides the form described in paragraph (a) of this subsection (11).

Source: L. 94: Entire section added, p. 1913, § 9, effective July 1. **L. 97:** (11) added, p. 1336, § 1, effective June 3. **L. 2004:** (11)(b) and (11)(c) amended, p. 935, § 2, effective May 21. **L. 2007:** (1) amended, p. 1754, § 4, effective January 1, 2009. **L. 2013:** (1), (3)(a), (5), and (11) amended and (4) repealed, (HB 13-1266), ch. 217, p. 955, § 17, effective May 13.

Cross references: For the legislative declaration contained in the 2004 act amending subsections (11)(b) and (11)(c), see section 1 of chapter 262, Session Laws of Colorado 2004.

10-16-109. Rules. Pursuant to article 4 of title 24, C.R.S., the commissioner may promulgate reasonable rules consistent with this article that are necessary or proper for implementing and administering this article, including rules necessary to align state law with the requirements imposed by federal law regarding health-care coverage in this state.

Source: L. 92: Entire article R&RE, p. 1655, § 1, effective July 1. **L. 2013:** Entire section amended, (HB 13-1266), ch. 217, p. 956, § 18, effective May 13.

Editor's note: The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

10-16-110. Fees paid by health coverage entities. (1) (a) There shall be paid to the division of insurance by every corporation subject to the provisions of this part 1 and part 3 of this article such fees as are prescribed pursuant to sections 10-3-207 and 24-31-104.5, C.R.S.

(b) Every nonprofit hospital and health service corporation representative subject to this part 1 and part 3 of this article shall pay to the commissioner the following fees:

(I) For each enrollment representative's initial license, ten dollars;

(II) For each enrollment representative's renewal license, six dollars.

(c) To defray the cost of administering this article, every corporation subject to the provisions of this part 1 and part 3 of this article shall pay annually to the commissioner on March 1 an amount equivalent to five cents per person exceeding ten thousand in number enrolled in the health service plans of such corporation.

(2) (a) Every health maintenance organization subject to this part 1 and part 4 of this article shall pay to the commissioner the fees as prescribed pursuant to sections 10-3-207 and 24-31-104.5, C.R.S.

(b) Every health maintenance organization representative subject to this part 1 and part 4 of this article shall pay to the commissioner the following fees:

(I) For each enrollment representative's initial license, ten dollars;

(II) For each enrollment representative's renewal license, six dollars.

(3) Coincident with the filing of the annual report prescribed by section 10-16-111, each prepaid dental care plan organization subject to this part 1 and part 5 of this article shall pay to the state treasurer through the commissioner fees for transacting a prepaid dental care plan. The fees shall be as prescribed pursuant to sections 10-3-207 and 24-31-104.5, C.R.S.

(4) Notwithstanding the amount specified for any fee in this section, the commissioner by rule or as otherwise provided by law may reduce the amount of one or more of the fees if necessary pursuant to section 24-75-402 (3), C.R.S., to reduce the uncommitted reserves of the fund to which all or any portion of one or more of the fees is credited. After the uncommitted reserves of the fund are sufficiently reduced, the commissioner by rule or as otherwise provided by law may increase the amount of one or more of the fees as provided in section 24-75-402 (4), C.R.S.

Source: L. 92: Entire article R&RE, p. 1655, § 1, effective July 1. **L. 98:** (4) added, p. 1328, § 33, effective June 1. **L. 2010:** (1)(a), (2)(a), and (3) amended, (HB 10-1385), ch. 204, p. 884, § 8, effective May 5. **L. 2012:** (1)(a), (2)(a), and (3) amended, (SB 12-110), ch. 158, p. 562, § 10, effective July 1.

Editor's note: The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

10-16-111. Annual statements and reports - rules. (1) **Nonprofit hospital, medical-surgical, and health service corporations.** (a) All corporations subject to the provisions of this part 1 and part 3 of this article doing business in this state on July 1, 1967, or which may thereafter do business in this state, shall make and file annually with the commissioner, on or before the first day of March of each year, a statement under oath upon a form prescribed by the commissioner stating the amount of all membership dues or subscriber fees collected in this state or from residents thereof by the corporation making such statement during the year ending the last day of December next preceding; the amounts actually paid during such year for hospital, medical-surgical, and other health services for the subscribers or members of the corporation, and the amounts placed in established reserves for cases billed but not yet paid, unreported and unbilled cases, retroactive cost adjustments, membership dues or fees paid in advance but not yet earned, and all other liabilities and obligations required of domestic insurers which are consistent with the responsibilities of such corporations. The annual statement made to the commissioner pursuant to this subsection (1) shall at least include the substance of that which is required by what is known as the convention blank form for hospital, medical, and dental service or indemnity corporations adopted from year to year by the national association of insurance commissioners, including any instructions, procedures, and guidelines not in conflict with any provision of this title for completing the convention blank form.

(b) In preparing the statements required by paragraph (a) of this subsection (1), all insurance companies shall follow the instructions, procedures, and guidelines of the national association of insurance commissioners. If the initial application of any such instruction, procedure, or guideline would cause a reduction in the total capital and surplus of a domestic insurer of ten percent or more or would cause the capital and surplus of a domestic insurer to fall to or below the company action level as defined by the commissioner by rule, such insurer may, within thirty days after the effective date of such instruction, procedure, or guideline, file with the commissioner a request to phase in the effect of the instruction, procedure, or guideline over a period not to exceed three years or a time period approved by the commissioner.

(c) Any request made pursuant to paragraph (b) of this subsection (1) shall include a complete analysis, in a form prescribed by the commissioner, of the impact upon the insurer making the request that is expected to result from application of the subject instruction, procedure, or guideline and, if a phase-in is requested, a description of the insurer's plan for the phase-in period. The commissioner shall not deny a request for a phase-in except upon notice and the opportunity for a hearing as provided in section 24-4-105, C.R.S.

(d) Any request for a hearing made pursuant to paragraph (c) of this subsection (1) shall include a description of the basis on which relief is sought. Upon receiving such a request, the commissioner shall postpone the effective date of the subject instruction, procedure, or guideline pending the conclusion of the hearing and the taking of final agency action thereon. The hearing shall commence within sixty days after the commissioner receives the request and shall be conducted in accordance with section 24-4-105, C.R.S.

(2) **Health maintenance organizations.** (a) Every health maintenance organization shall annually, on or before March 1, file a report verified by at least two principal officers with the commissioner covering the preceding calendar year.

(b) The report must be on forms prescribed by the commissioner and shall include:

(I) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant;

(II) Any material changes in the information submitted pursuant to section 10-16-401 (3);

(III) The number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;

(IV) A summary of information compiled pursuant to section 10-16-402 (1)(b)(III) in such form as required by the commissioner;

(V) Such other information relating to the performance of the health maintenance organization as is necessary to enable the commissioner to carry out the commissioner's duties under this part 1 and part 4 of this article.

(c) and (d) Repealed.

(e) Each health maintenance organization shall report to the commissioner within five days of receipt or determination of a noncompliance order issued by the United States department of health and human services. Each health maintenance organization shall report to the commissioner within five days of receipt of determination by the United States department of health and human services or the health maintenance organization or a creditor or guarantor as to repayment schedule of loans or modification of financial commitments. The report shall include any determination for the ensuing twelve-month period. Upon providing such report, the health maintenance organization shall submit a revised financial statement recognizing the appropriate amounts as a direct liability.

(3) **Prepaid dental care plan organizations.** (a) Every prepaid dental care plan organization subject to this part 1 and part 5 of this article shall file with the commissioner annually, on or before March 1, a report verified by at least two principal officers covering the preceding calendar year.

(b) Such report shall be on forms prescribed by the commissioner and shall include:

(I) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant;

(II) Any material changes in the information submitted pursuant to section 10-16-503 (1);

(III) The number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;

(IV) Statistics relating to the cost of its operations, the pattern of utilization of its services, and the availability and accessibility of its services;

(V) Such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out the commissioner's duties under this part 1 and part 5 of this article.

(4) **Carriers.** (a) On or before June 1 of each year, a carrier doing business in this state that satisfies qualifications as determined by rule of the commissioner shall submit to the commissioner, where applicable, the following cost information for the previous calendar year:

(I) Medical trend itemized by medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology;

(II) Medical trend itemized by pharmaceutical price increases, utilization changes, cost shifting, and the introductions of new brand and generic drugs;

(III) Dividends paid;

(IV) Executive salaries, stock options, or bonuses;

(V) Insurance producer commissions;

(VI) Payments to legal counsel;

(VII) Provision for profit and contingencies;

(VIII) Administrative expenditures with breakdowns for advertising or marketing expenditures, paid lobbying expenditures, and staff salaries;

(IX) Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses;

(X) Charitable contributions;

(XI) Losses on investments or investment income;

(XII) Reserves on hand;

(XIII) The amount of surplus and the amount of surplus relative to the carrier's risk-based capital requirement;

(XIV) Taxes itemized by category;

(XV) Administrative ratio;

(XVI) Actual benefits ratio;

(XVII) The number of lives insured under each benefit plan the carrier offers to small employers;

(XVIII) The cost of providing or arranging health-care services; and

(XIX) A list of each intermediary with whom the carrier has a contractual relationship.

(a.5) Repealed.

(b) A carrier licensed in multiple jurisdictions may satisfy the requirements of paragraph (a) of this subsection (4) by filing the Colorado allocated portion of national data if the actual data is not otherwise available.

(c) The commissioner shall aggregate the data submitted pursuant to paragraph (a) of this subsection (4) for all carriers and publish the information on the division's website. Notwithstanding section 24-1-136 (11)(a)(I), the commissioner shall submit a report annually to the general assembly that analyzes the cost of health care and the factors that drive the cost of health care on an individual and group basis in this state.

(d) Notwithstanding section 24-1-136 (11)(a)(I), the commissioner shall report annually to the general assembly regarding financial information on carriers that includes, but is not limited to, benefits ratios, rate increases, and the reasons or data tracked for cost increases, as applicable for health insurance provided pursuant to this article.

(e) When promulgating rules pursuant to paragraph (a) of this subsection (4), the commissioner shall ensure that at least ninety-two percent of the market share reports cost information.

Source: L. 92: Entire article R&RE, p. 1656, § 1, effective July 1; (1) amended, p. 1592, § 113, effective July 1. **L. 94:** (1) amended, p. 595, § 1, effective April 7. **L. 97:** (1) amended, p. 92, § 3, effective March 24. **L. 99:** (2)(c) and (2)(d) repealed, p. 85, § 7, effective July 1. **L. 2008:** (4) added, p. 2255, § 9, effective July 1. **L. 2011:** (4)(a.5) added, (SB 11-128), ch. 133, p. 469, § 4, effective April 29. **L. 2013:** IP(4)(a), (4)(a)(XVII), and (4)(a)(XVIII) amended and (4)(a)(XIX) and (4)(e) added, (HB 13-1223), ch. 145, p. 468, § 1, effective April 26. **L. 2017:** (2)(a), IP(2)(b), and (2)(b)(IV) amended, (SB 17-249), ch. 283, p.1547, § 12, effective June 1; (4)(c) and (4)(d) amended, (SB 17-044), ch. 4, p. 7, § 3, effective August 9.

Editor's note: (1) The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

(2) Subsection (4)(a.5)(II) provided for the repeal of subsection (4)(a.5), effective January 1, 2014. (See L. 2011, p. 469.)

Cross references: (1) In 2008, subsection (4) was enacted by the "Fair Accountable Insurance Rates Act". For the short title and legislative declaration, see sections 1 and 2 of chapter 439, Session Laws of Colorado 2008.

(2) For the legislative declaration in the 2011 act adding subsection (4)(a.5), see section 1 of chapter 133, Session Laws of Colorado 2011.

10-16-112. Private utilization review - health-care coverage entity responsibility - definitions. (1) As used in this section, unless the context otherwise requires:

(a) "Private utilization review organization" means an entity, other than a hospital or public reviewer following federal guidelines, that conducts utilization review or reviews and makes determinations on prior authorization requests for health-care services as described in section 10-16-112.5. This definition shall not apply to any independent medical examination provided for in any policy of insurance.

(b) "Utilization review" means an evaluation of the necessity, appropriateness, and efficiency of the use of health-care services, procedures, and facilities, but does not include any independent medical examination provided for in any policy of insurance.

(2) Any private utilization review organization providing services to an insurance carrier, nonprofit hospital and health-care service corporation, or health maintenance organization regulated pursuant to the provisions of this article is the direct representative of the insurance carrier, nonprofit hospital and health-care service corporation, or health maintenance organization. Any insurance carrier, nonprofit hospital and health-care service corporation, or health maintenance organization is responsible for the actions of any private utilization review organization acting within the scope of any contract and on its behalf within the scope of any contract which result in any violation of this title or any rules or regulations promulgated by the commissioner.

Source: L. 93: Entire section added, p. 494, § 2, effective April 26. **L. 2019:** (1)(a) amended, (HB 19-1211), ch. 165, p. 1910, § 3, effective August 2.

Cross references: For the legislative declaration in HB 19-1211, see section 1 of chapter 165, Session Laws of Colorado 2019.

10-16-112.5. Prior authorization for health-care services - disclosures and notice - determination deadlines - criteria - limits and exceptions - enforcement - definitions - rules. (1) **Applicability.** (a) On or after January 1, 2020, a carrier or, if a carrier contracts with a private utilization review organization to perform prior authorization for health-care services, the organization shall use the prior authorization process and comply with the requirements specified in this section. Except as otherwise specified in this section, this section applies to prior

authorization requests for health-care services, excluding requests for drug benefits pursuant to section 10-16-124.5.

(b) This section does not apply to:

(I) A health maintenance organization with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group;

(II) A nonprofit health maintenance organization operated by or under the control of the Denver health and hospital authority created by article 29 of title 25 or any subsidiary of the authority; or

(III) Carriers, organizations, and medical benefits subject to the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8.

(2) **Disclosure of requirements - notice of changes - rules.** (a) **[*Editor's note: For the applicability of this subsection (2)(a) on or after January 1, 2026, see the editor's note following this section.*]**

(I) A carrier shall post current prior authorization requirements and restrictions, including written, clinical criteria, on the carrier's public-facing website in a readily accessible, standardized, searchable format. The prior authorization requirements must be described in detail and in clear and easily understandable language.

(II) If a carrier contracts with a private utilization review organization to perform prior authorization for health-care services, the organization shall provide its prior authorization requirements and restrictions, as required by this subsection (2), to the carrier with which the organization contracted, and that carrier shall post the organization's prior authorization requirements and restrictions on its public-facing website in the manner required by subsection (2)(a)(I) of this section.

(b) If a carrier or organization intends to implement a new prior authorization requirement or restriction or to amend an existing requirement or restriction, the carrier or organization shall:

(I) Notify any participating providers of the new or amended requirement or restriction in the manner and within the time specified in section 25-37-102 (9)(c) or 25-37-104 (1), as applicable; and

(II) Update the prior authorization information posted on the carrier's website pursuant to subsection (2)(a) of this section to reflect the new or amended prior authorization requirement or restriction before implementing the new or amended requirement or restriction.

(c) **[*Editor's note: For the applicability of this subsection (2)(c) on or after January 1, 2026, see the editor's note following this section.*]**

(I) A carrier shall post, on a public-facing portion of its website, data regarding approvals and denials of prior authorization requests, including requests for drug benefits pursuant to section 10-16-124.5, in a readily accessible, standardized, searchable format and that include the following:

(A) The total number of prior authorization requests received in the immediately preceding calendar year in each of the following categories of services: Medical procedures, diagnostic tests and diagnostic images, prescription drugs, and all other categories of health-care services or drug benefits for which a prior authorization request was received;

(B) The total number of prior authorization requests that were approved in each of the categories specified in subsection (2)(c)(I)(A) of this section;

(B.5) The total number of prior authorization requests for which an adverse determination was issued and the service was denied in each of the categories specified in subsection (2)(c)(I)(A) of this section;

(C) The reason for the denial in each of the categories specified in subsection (2)(c)(I)(A) of this section, with the denial reasons sorted by categories defined by rule; and

(D) In each of the categories specified in subsection (2)(c)(I)(A) of this section, the total number of adverse determinations that were appealed and whether the determination was upheld or reversed on appeal.

(II) An organization or PBM that provides prior authorization for a carrier shall provide the data specified in subsection (2)(c)(I) of this section to the carrier with which the organization or PBM contracted, and the carrier shall post the organization's or PBM's data on its public-facing website in the manner required by subsection (2)(c)(I) of this section.

(III) Carriers and organizations shall use the data specified in this subsection (2)(c) to refine and improve their utilization management programs. Carriers and organizations shall review the list of medical procedures, diagnostic tests and diagnostic images, prescription drugs, and other health-care services for which the carrier or organization requires prior authorization at least annually and shall eliminate the prior authorization requirements for those procedures, diagnostic tests and diagnostic images, prescription drugs, or other health-care services for which prior authorization neither promotes health-care quality or equity nor substantially reduces health-care spending. Each carrier and organization shall annually attest to the commissioner that it has completed the review required by this subsection (2)(c)(III) and has eliminated prior authorization requirements consistent with the requirements of this subsection (2)(c)(III).

(IV) A carrier shall post, on a public-facing portion of its website, in a readily accessible, standardized, searchable format, data on the number of exemptions from prior authorization requirements or alternatives to prior authorization requirements provided pursuant to a program adopted by the carrier, organization, or PBM pursuant to subsection (4)(b)(II) of this section or section 10-16-124.5 (5.5), as applicable. The carrier shall include the following data:

(A) The number of providers offered an exemption or alternative program, including their specialty areas;

(B) The number and categorized types of exemptions or alternative programs offered to providers; and

(C) The prescription drug, diagnostic test, procedure, or other health-care service for which an exemption or alternative program was offered.

(V) The commissioner shall adopt rules to:

(A) Implement subsections (2)(c)(I) and (2)(c)(IV) of this section to ensure that the data fields required to be posted pursuant to subsections (2)(c)(I) and (2)(c)(IV) of this section are presented consistently by carriers; and

(B) Define categories of prior authorization request denials for purposes of subsection (2)(c)(I)(C) of this section.

(3) **Nonurgent and urgent health-care services - timely determination - notice of determination - deemed approved.** (a) Except as provided in subsection (3)(b) of this section, a prior authorization request is deemed granted if a carrier or organization fails to:

(I) **[*Editor's note: For the applicability of this subsection (3)(a)(I) on or after January 1, 2026, see the editor's note following this section.*]**

(A) Notify the provider and covered person, within five business days after receipt of the request, that the request is approved, denied, or incomplete and indicate: If denied, what relevant alternative services or treatments may be a covered benefit or are required before approval of the denied service or treatment or, if incomplete, the specific additional information, consistent with criteria posted pursuant to subsection (2)(a) of this section, that is required to process the request; or

(B) Notify the provider and covered person, within five business days after receiving the additional information required by the carrier or organization pursuant to subsection (3)(a)(I)(A) of this section, that the request is approved or denied and, if denied, indicate what relevant alternative services or treatments may be a covered benefit or are required before approval of the denied service or treatment; and

(II) For a prior authorization request for urgent health-care services:

(A) Notify the provider and covered person, within two business days but not longer than seventy-two hours after receipt of the request, that the request is approved, denied, or incomplete and, if incomplete, indicate the specific additional information, consistent with criteria posted pursuant to subsection (2)(a) of this section, that is required to process the request; or

(B) Notify the provider and covered person, within two business days but not longer than seventy-two hours after receiving the additional information required by the carrier or organization pursuant to subsection (3)(a)(II)(A) of this section, that the request is approved or denied.

(b) If a carrier or organization notifies the provider and covered person pursuant to subsection (3)(a)(I)(A) or (3)(a)(II)(A) of this section that a prior authorization request is incomplete and that additional information is required, the provider shall submit the additional information within two business days after receipt of the notice from the carrier or organization. If the provider fails to submit the required additional information within two business days after receipt of the notice, the request is not deemed granted pursuant to subsection (3)(a) of this section. After receipt of the required additional information, the carrier or organization shall respond to the prior authorization request in accordance with subsection (3)(a)(I)(B) of this section or, for a prior authorization request for urgent health-care services, subsection (3)(a)(II)(B) of this section.

(c) (I) When notifying the provider of the determination on a prior authorization request, the carrier or organization shall provide a unique prior authorization number attributable to that request and the particular health-care service that is the subject of the request.

(II) **[*Editor's note: For the applicability of this subsection (3)(c)(II) on or after January 1, 2026, see the editor's note following this section.*]** If the carrier or organization denies a prior authorization request based on a ground specified in section 10-16-113 (3)(a), the notification is subject to the requirements of section 10-16-113 (3)(a) and commissioner rules adopted pursuant to that section and must:

(A) Include information concerning whether the carrier or organization requires an alternative treatment, test, procedure, or medication and what alternative services or treatments would be approved as a covered benefit under the health benefit plan; or

(B) In the case of the denial of a prior authorization request for a prescription drug, specify which prescription drugs and dosages in the same class as the prescription drug for

which the prior authorization request was denied are covered prescription drugs under the health benefit plan.

(III) **[*Editor's note: For the applicability of this subsection (3)(c)(III) on or after January 1, 2026, see the editor's note following this section.*]** A carrier's, organization's, or pharmacy benefit manager's compliance with subsection (3)(c)(II) of this section does not constitute the practice of medicine.

(d) This subsection (3) does not apply to prior authorization requests for drug benefits that are subject to section 10-16-124.5; except that subsection (3)(c)(II) of this section applies to prior authorization requests for drug benefits.

(3.5) **[*Editor's note: For the applicability of this subsection (3.5) on or after January 1, 2026, see the editor's note following this section.*]**

(a) Starting January 1, 2027, a carrier or organization shall have, maintain, and use a prior authorization application programming interface that automates the prior authorization process to enable a provider to:

(I) Determine whether prior authorization is required for a health-care service;

(II) Identify prior authorization information and documentation requirements; and

(III) Facilitate the exchange of prior authorization requests and determinations from the provider's electronic health records or practice management systems through secure electronic transmission.

(b) A carrier's or organization's application programming interface must meet the most recent standards and implementation specifications adopted by the secretary of the United States department of health and human services as specified in 45 CFR 170.215 (a).

(c) If a provider submits a prior authorization request through the carrier's or organization's application programming interface, the carrier or organization shall accept and respond to the request through the interface.

(4) **Criteria, limits, and exceptions - program.** (a) Carriers and organizations shall:

(I) Use prior authorization criteria that are current, clinically based, aligned with other quality initiatives of the carrier or organization, and aligned with other carriers' and organizations' prior authorization criteria for the same health-care services;

(II) Ensure that prior authorization requests are reviewed by appropriate providers; and

(III) Make eligibility, benefit coverage, and medical policy determinations as part of the prior authorization process.

(b) **[*Editor's note: For the applicability of this subsection (4)(b) on or after January 1, 2026, see the editor's note following this section.*]**

(I) Carriers and organizations shall consider limiting the use of prior authorization to providers whose prescribing or ordering patterns differ significantly from the patterns of their peers after adjusting for patient mix and other relevant factors and present opportunities for improvement in adherence to the carrier's or organization's prior authorization requirements.

(II) No later than January 1, 2026, a carrier or an organization shall adopt a program, developed in consultation with providers participating with the carrier, to eliminate or substantially modify prior authorization requirements in a manner that removes the administrative burden for qualified providers, as defined under the program, and their patients for certain health-care services and related benefits based on any of the following:

(A) The performance of providers with respect to adherence to nationally recognized, evidence-based medical guidelines, appropriateness, efficiency, and other quality criteria; and

(B) Provider specialty, experience, or other objective factors; except that eligibility for the program must not be limited by provider specialty.

(III) A program developed pursuant to subsection (4)(b)(II) of this section:

(A) Must not require qualified providers to request participation in the program; and

(B) May include limiting the use of prior authorization to providers whose prescribing or ordering patterns differ significantly from the patterns of their peers after adjusting for patient mix and other relevant factors and in order to present those providers with opportunities for improvement in adherence to the carrier's or organization's prior authorization requirements.

(IV) At least annually, a carrier or an organization shall:

(A) Reexamine a provider's prescribing or ordering patterns;

(B) Reevaluate the provider's status for exemption from prior authorization requirements or for inclusion in the program developed pursuant to subsection (4)(b)(II) of this section; and

(C) Notify the provider of the provider's status for exemption or inclusion in the program.

(V) A program developed pursuant to subsection (4)(b)(II) of this section must include procedures for a provider to request:

(A) An expedited, informal resolution of a carrier's or an organization's failure or refusal to include the provider in the program; and

(B) If the matter is not resolved through informal resolution, binding arbitration as specified in subsection (4)(b)(VI) of this section.

(VI) If a provider requests binding arbitration pursuant to the procedures a carrier or an organization develops under subsection (4)(b)(V)(B) of this section, the following provisions govern the arbitration procedure:

(A) The provider and carrier or organization shall jointly select an arbitrator from the list of arbitrators approved pursuant to section 10-16-704 (15)(b). Neither the provider nor the carrier or organization is required to notify the division of the arbitration or of the selected arbitrator.

(B) The selected arbitrator shall determine the provider's eligibility to participate in the carrier's or organization's program based on the program criteria developed pursuant to subsection (4)(b)(II) of this section;

(C) Within thirty days after the date the arbitrator accepts the matter, the provider and the carrier or organization shall submit to the arbitrator written materials in support of their respective positions;

(D) The arbitrator may render a decision based on the written materials submitted pursuant to subsection (4)(b)(VI)(C) of this section or may schedule a hearing, lasting not longer than one day, for the provider and carrier or organization to present evidence;

(E) Within thirty days after the date the arbitrator receives the written materials or, if a hearing is conducted, the date of the hearing, the arbitrator shall issue a written decision stating whether the provider is eligible for the program; and

(F) If the arbitrator overturns the carrier's or organization's failure or refusal to include the provider in the program, the carrier or organization shall pay the arbitrator's fees and costs, and if the arbitrator affirms the carrier's or organization's failure or refusal to include the provider in the program, the provider shall pay the arbitrator's fees and costs.

(c) **[*Editor's note: For the applicability of this subsection (4)(c) on or after January 1, 2026, see the editor's note following this section.*]**

(I) When a carrier or an organization approves a prior authorization request for a surgical procedure for which prior authorization is required, the carrier or organization shall not deny a claim for an additional or a related health-care procedure identified during the authorized surgical procedure if:

(A) The provider, while providing the approved surgical procedure to treat the covered person, determines, in accordance with generally accepted standards of medical practice, that providing a related health-care procedure, instead of or in addition to the approved surgical procedure, is medically necessary as part of the treatment of the covered person and that, in the provider's clinical judgment, to interrupt or delay the provision of care to the covered person in order to obtain prior authorization for the additional or related health-care procedure would not be medically advisable;

(B) The additional or related health-care procedure is a covered benefit under the covered person's health benefit plan;

(C) The additional or related health-care procedure is not experimental or investigational;

(D) After completing the additional or related health-care procedure and before submitting a claim for payment, the provider notifies the carrier or organization that the provider performed the additional or related health-care procedure and includes in the notice the information required under the carrier's or organization's current prior authorization requirements posted in accordance with subsection (2)(a)(I) of this section; and

(E) The provider is compliant with the carrier's or organization's post-service claims process, including submission of the claim within the carrier's or organization's required timeline for claims submissions.

(II) When a provider provides an additional or a related health-care procedure as described in this subsection (4)(c), the carrier or organization shall not deny the claim for the initial surgical procedure for which the carrier or organization approved a prior authorization request on the basis that the provider provided the additional or related health-care procedure.

(5) **Duration of approval.** (a) **[*Editor's note: For the applicability of this subsection (5)(a) on or after January 1, 2026, see the editor's note following this section.*]** Upon approval by the carrier or organization, a prior authorization is valid for at least one calendar year after the date of approval and continues for the duration of the authorized course of treatment. Except as provided in subsection (5)(b) of this section, once approved, a carrier or an organization shall not retroactively deny the prior authorization request for a health-care service.

(b) If there is a change in coverage of or approval criteria for a previously approved health-care service, the change in coverage or approval criteria does not affect a covered person who received prior authorization before the effective date of the change for the remainder of the covered person's plan year.

(c) Subsections (5)(a) and (5)(b) of this section do not apply if:

(I) The prior authorization approval was based on fraud;

(II) The provider never performed the services that were requested for prior authorization;

(III) The service provided did not align with the service that was authorized;

(IV) The person receiving the service no longer had coverage under the health coverage plan on or before the date the service was delivered; or

(V) The covered person's benefit maximums were reached on or before the date the service was delivered.

(6) **Rules - enforcement. [*Editor's note: For the applicability of this subsection (6) on or after January 1, 2026, see the editor's note following this section.*]**

(a) The commissioner may adopt rules as necessary to implement this section.

(b) The commissioner may enforce the requirements of this section and impose a penalty or other remedy against a person that violates this section.

(7) **Definitions.** As used in this section:

(a) "Approval" means a determination by a carrier or organization that a health-care service has been reviewed and, based on the information provided, satisfies the carrier's or organization's requirements for medical necessity and appropriateness and that payment will be made for that health-care service.

(b) "Clinical criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and other criteria or rationale used by the carrier or organization to determine the necessity and appropriateness of health-care services.

(c) "Medical necessity" means a determination by the carrier that a prudent provider would provide a particular covered health-care service to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptom in a manner that is:

(I) In accordance with generally accepted standards of medical practice and approved by the FDA or other required agency;

(II) Clinically appropriate in terms of type, frequency, extent, service site, and level and duration of service;

(III) Known to be effective in improving health, as proven by scientific evidence;

(IV) The most appropriate supply, setting, or level of service that can be safely provided given the patient's condition and that cannot be omitted;

(V) Not experimental or investigational;

(VI) Not more costly than an alternative drug, service, service site, or supply that is not contraindicated for the patient's condition or safety and is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of an illness, injury, disease, or symptom; and

(VII) Not primarily for the economic benefit of carriers and purchasers or for the convenience of the patient, treating provider, or other provider.

(d) "Prior authorization" means the process by which a carrier or organization determines the medical necessity and appropriateness of otherwise covered health-care services prior to the rendering of the services. "Prior authorization" includes preadmission review, pretreatment review, utilization review, and case management and a carrier's or organization's requirement that a covered person or provider notify the carrier or organization prior to receiving or providing a health-care service.

(e) **[*Editor's note: For the applicability of this subsection (7)(e) on or after January 1, 2026, see the editor's note following this section.*]** "Private utilization review organization" or "organization" means a private utilization review organization, as defined in section 10-16-112 (1)(a), that has a contract with and performs prior authorization on behalf of a carrier.

(f) "Urgent health-care service" means a health-care service that, in the opinion of the provider based on the covered person's medical condition, if subjected to the prior authorization time period for a nonurgent health-care service, could:

(I) Seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;

(II) For a person with a physical or mental disability, create an imminent and substantial limitation on the person's existing ability to live independently; or

(III) Subject the covered person to severe pain that cannot be adequately managed without the particular health-care service.

Source: L. 2019: Entire section added, (HB 19-1211), ch. 165, p. 1904, § 2, effective August 2. **L. 2022:** (7)(c)(I) amended, (HB 22-1264), ch. 126, p. 888, § 3, effective August 10. **L. 2024:** (2)(a), (2)(c), (3)(a)(I), (3)(c)(II), (4)(b), (5)(a), (6), and (7)(e) amended and (3)(c)(III), (3.5), and (4)(c) added, (HB 24-1149), ch. 333, p. 2255, § 2, effective August 7.

Editor's note: Section 5(2) of chapter 333 (HB 24-1149), Session Laws of Colorado 2024, provides that the act changing this section applies to conduct occurring on or after January 1, 2026.

Cross references: For the legislative declaration in HB 19-1211, see section 1 of chapter 165, Session Laws of Colorado 2019. For the legislative declaration in HB 24-1149, see section 1 of chapter 333, Session Laws of Colorado 2024.

10-16-113. Procedure for denial of benefits - internal review - rules - definitions. (1) (a) A carrier shall not make an adverse determination, in whole or in part, with respect to a health coverage plan unless the determination is made pursuant to this section.

(b) For the purposes of this section:

(I) "Adverse determination" means:

(A) A denial of a preauthorization for a covered benefit;

(B) A denial of a request for benefits for an individual on the ground that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health-care setting or level of care;

(C) A rescission or cancellation of coverage under a health coverage plan that is not attributable to failure to pay premiums and that is applied retroactively;

(D) A denial of a request for benefits on the ground that the treatment or service is experimental or investigational; or

(E) A denial of coverage to an individual based on an initial eligibility determination for all individual sickness and accident insurance policies issued by an entity subject to part 2 of this article, and all individual health-care or indemnity contracts issued by an entity subject to part 3 or 4 of this article, except supplemental policies covering a specified disease or other limited benefit.

(II) "Health coverage plan" does not include insurance arising out of the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S., or other similar law, automobile medical payment insurance, or property and casualty insurance.

(III) "Individual" means a person and includes the designated representative of an individual.

(c) If a carrier denies a benefit because the treatment is an excluded benefit and the claimant presents evidence from a medical professional licensed pursuant to the "Colorado Medical Practice Act", article 240 of title 12, or, for dental plans only, a dentist licensed pursuant to the "Dental Practice Act", article 220 of title 12, acting within his or her scope of practice, that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, such evidence establishes that the benefit denial is subject to the appeals process pursuant to this section and section 10-16-113.5.

(2) Following a denial of a request for benefits or an adverse determination by the carrier, the carrier shall notify the individual in writing. The commissioner shall adopt rules specifying the content of the notification and the deadlines for making the notification, and the carrier shall notify the individual in accordance with those rules.

(3) (a) (I) All denials of requests for reimbursement for medical treatment, standing referrals, or adverse determinations made on the ground that a treatment or covered benefit is not medically necessary, appropriate, effective, or efficient, is not delivered in the appropriate setting or at the appropriate level of care, or is experimental or investigational, must include:

(A) An explanation of the specific medical basis for the denial;

(B) The specific reasons for the denial or adverse determination;

(C) Reference to the specific health coverage plan provisions on which the determination is based;

(D) A description of the carrier's review procedures and the time limits applicable to such procedures and a statement that the individual has the right to appeal the decision; and

(E) A description of any additional material or information necessary, if any, for the individual to perfect the request for benefits and an explanation of why the material or information is necessary.

(II) In the case of an adverse determination by a carrier:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the carrier shall furnish the individual with either the specific rule, guideline, protocol, or other similar criterion, or a statement that the rule, guideline, protocol, or other criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to the individual upon request; or

(B) If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the carrier shall furnish the individual with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the individual's medical circumstances, or a statement that the explanation will be provided free of charge upon request.

(III) In the event of an adverse determination by a carrier concerning a request involving urgent care, a carrier:

(A) Shall provide to the individual a description of the expedited review process applicable to the request;

(B) May communicate the other information required pursuant to subparagraph (I) of this paragraph (a) to the individual orally within the time frame outlined in 29 CFR 2560.503-1

(f)(2)(i) so long as a written or electronic copy of the information is furnished to the individual no later than three days after the oral notification; and

(C) May waive the deadlines specified in sub-subparagraph (B) of this subparagraph (III) and in subparagraph (IV) of this paragraph (a) to permit the individual to pursue an expedited external review of the urgent care claim under section 10-16-113.5.

(IV) A carrier shall notify an individual of a benefit determination, whether adverse or not, with respect to a request involving urgent care as soon as possible, taking into account the medical exigencies, but not later than seventy-two hours after the receipt of the request by the carrier, unless the individual fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the coverage.

(b) (I) A group health coverage plan issued by a carrier subject to part 2, 3, or 4 of this article must specify that an appeal of any adverse determination includes a two-level internal review of the decision, followed by the right of the individual to request an external review if allowed under section 10-16-113.5. The individual has the option of choosing whether to utilize the voluntary second-level internal appeal process.

(II) The carrier shall notify the individual of his or her right to appeal a denial of benefits through a two-level internal review process and that the second level of internal review may be utilized at the individual's option.

(III) (A) A physician shall evaluate the first-level appeal and shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer; except that, in the case of dental care, a dentist may evaluate the first-level appeal, and the reviewing dentist shall consult with an appropriate clinical peer or peers, unless the reviewing dentist is a clinical peer. A physician, dentist, or clinical peer who was involved in the initial adverse determination shall not evaluate or be consulted regarding the first-level appeal. A person who was previously involved with the denial may answer questions.

(B) This subparagraph (III) does not apply to an adverse determination described in sub-subparagraph (C) or (E) of subparagraph (I) of paragraph (b) of subsection (1) of this section.

(IV) (A) The second-level internal review of an appeal from the denial of a request for covered benefits pursuant to subparagraph (I) of this paragraph (b) shall be reviewed by a health-care professional who has appropriate expertise, who was not previously involved in the appeal, and who does not have a direct financial interest in the appeal or outcome of the review.

(B) The carrier shall allow the individual to be present for the second-level internal review, either in person or by telephone conference. The individual may bring counsel, advocates, and health-care professionals to the review, prepare in advance for the review, and present materials to the health-care professional prior to the review and at the time of the review. Upon request, the carrier and the individual shall provide copies of the materials they intend to present at the review to the other party at least five days prior to the review. If new information is developed after the five-day deadline, the material may be presented when practicable. The carrier shall notify the individual that the carrier will make an audio or video recording of the review unless neither the individual nor the carrier wants the recording made. If a recording is made, the carrier shall make the recording available to the individual. If there is an external review, the carrier shall include the audio or video recording in the material provided by the carrier to the reviewing entity if requested by either party.

(c) In addition to the requirements specified in subsections (3)(a) and (3)(b) of this section, unless a denial is based on nonpayment of premiums, a denial of reimbursement for

services for the prevention of, screening for, or treatment of behavioral, mental health, and substance use disorders under a health benefit plan must include the following, in plain language:

(I) A statement explaining that covered persons are protected under the MHPAEA, which provides that limitations placed on access to mental health and substance use disorder benefits may be no greater than any limitations placed on access to medical and surgical benefits;

(II) A statement providing information about contacting the division or the office of the ombudsman for behavioral health access to care established pursuant to part 3 of article 80 of title 27 if the covered person believes his or her rights under the MHPAEA have been violated; and

(III) A statement specifying that covered persons are entitled, upon request to the carrier and free of charge, to a copy of the medical necessity criteria for any behavioral, mental health, and substance use disorder benefit.

(4) (a) Each carrier issuing individual health coverage plans shall notify the individual of his or her right to appeal an adverse determination through a single level of internal review.

(b) (I) A physician shall evaluate the appeal and consult with an appropriate clinical peer or peers unless the reviewing physician is a clinical peer; except that, in the case of dental care, a dentist may evaluate the appeal, and the reviewing dentist shall consult with an appropriate clinical peer or peers. A physician, dentist, or clinical peer who was involved in the initial adverse determination shall not evaluate or be consulted regarding the appeal. A person who was previously involved with the denial may answer questions.

(II) This paragraph (b) does not apply to an adverse determination described in sub-subparagraph (C) or (E) of subparagraph (I) of paragraph (b) of subsection (1) of this section.

(c) The carrier shall allow the individual to be present for the appeal. The individual may bring counsel, advocates, and health-care professionals to the review, prepare in advance for the review, and present materials to the physician or dentist prior to the review and at the time of the review. Upon request, the carrier and the individual shall provide copies of the materials they intend to present at the review to the other party at least five days prior to the review. If new information is developed after the five-day deadline, the material may be presented when practicable. The carrier shall notify the individual that the carrier will make an audio or video recording of the review unless neither the individual nor the carrier wants the recording made. If a recording is made, the carrier shall make the recording available to the individual. If there is an external review, the carrier shall include the audio or video recording in the material provided by the carrier to the reviewing entity if requested by either party.

(5) All written adverse determinations, except an adverse determination described in sub-subparagraph (C) or (E) of subparagraph (I) of paragraph (b) of subsection (1) of this section, must be signed by a licensed physician familiar with standards of care in Colorado; except that, in the case of written adverse determinations relating to dental care, a licensed dentist familiar with standards of care in Colorado may sign the written adverse determination.

(6) An individual's health-care provider may communicate with the physician or dentist involved in the initial decision to make an adverse determination.

(7) Nothing in this section precludes or denies the right of an individual to seek any other remedy or relief.

(8) In the case of the failure of a carrier to adhere to the requirements of this section with respect to a coverage request, the individual may be deemed to have exhausted the internal claims and appeals process of this section if the commissioner determines that the carrier did not substantially comply with the requirements of this section or that any error the carrier committed was not de minimis, as defined by the commissioner by rule, in which case the individual may initiate an external review under section 10-16-113.5.

(9) Carriers shall maintain records of all requests and notices associated with the internal claims and appeals process for six years and shall make such records available upon request for examination by the individual, the division of insurance, or the federal government.

(10) The commissioner may promulgate rules as necessary for the implementation and administration of this section.

Source: L. 97: Entire section added, p. 1334, § 1, effective July 1. **L. 99:** (3) amended, p. 320, § 4, effective July 1; (3) amended, p. 1047, § 1, effective June 1, 2000. **L. 2003:** (1) to (4), (6), and (7) amended, p. 1384, § 1, effective January 1, 2004. **L. 2004:** (3)(b)(I) amended, p. 988, § 7, effective August 4. **L. 2005:** (1)(c), (3)(b)(IV), (3)(b)(V), and (3)(b)(VI) added and (3)(b)(I) amended, p. 803, §§ 1, 2, effective January 1, 2006. **L. 2008:** (3)(b)(V), (4), and (5) amended, p. 83, § 1, effective August 5. **L. 2013:** Entire section amended, (HB 13-1266), ch. 217, p. 956, § 19, effective May 13. **L. 2014:** (1)(c) amended, (HB 14-1277), ch. 363, p. 1735, § 37, effective July 1. **L. 2019:** (3)(c) added, (HB 19-1269), ch. 195, p. 2128, § 6, effective May 16; (1)(c) amended, (HB 19-1172), ch. 136, p. 1654, § 44, effective October 1.

Editor's note: Amendments to subsection (3) by House Bill 99-1306 and Senate Bill 99-141 were harmonized.

Cross references: (1) For the legislative declaration contained in the 1999 act amending subsection (3), see section 1 of chapter 111, Session Laws of Colorado 1999.

(2) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

10-16-113.5. Independent external review of adverse determinations - legislative declaration - definitions - rules. (1) The general assembly hereby finds, determines, and declares that, in the interest of improving accountability for health-care coverage decisions, individuals should have the option of an independent external review by qualified experts when there has been an adverse determination with respect to a health coverage plan pursuant to a carrier's procedures as required by section 10-16-113.

(2) As used in this section, unless the context otherwise requires:

(a) "Adverse determination" means a denial of:

(I) A preauthorization for a covered benefit;

(II) A request for benefits for an individual on the grounds that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health-care setting or level of care;

(III) A request for benefits on the grounds that the treatment or services are experimental or investigational;

(IV) A benefit as described in section 10-16-113 (1)(c); or

(V) A request for benefits for a prescription drug that is unavailable in the state because a manufacturer has withdrawn the prescription drug from sale or distribution within the state under section 10-16-1412.

(b) "Division" means the division of insurance in the department of regulatory agencies, established in section 10-1-103.

(c) "Expedited review" means a review following completion of procedures for expedited internal review of an adverse determination involving a situation where the time frame of the standard independent external review procedures would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function. Expedited review is available if the adverse determination concerns an admission, availability of care, continued stay, or health-care services for which the individual received emergency services, and the individual has not been discharged from a facility.

(d) (I) "Expert reviewer" means a physician or other appropriate health-care provider assigned by an independent external review entity to conduct an independent external review. An expert reviewer shall not:

(A) Have been involved in the individual's care previously;

(B) Be a member of the board of directors of the carrier;

(C) Have been previously involved in the review process for the individual requesting an independent external review;

(D) Have a direct financial interest in the case or in the outcome of the review; or

(E) Be an employee of the carrier.

(II) Physicians or other appropriate health-care providers who are expert reviewers must:

(A) Be experts in the treatment of the medical condition of the individual requesting an independent external review and knowledgeable about the recommended treatment or service that is the subject of the review through the expert's actual, current clinical experience;

(B) Hold a license issued by a state and, for physicians, a current certification by a recognized American medical specialty board in the area appropriate to the subject of review; and

(C) Have no history of disciplinary action or sanction, including loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(e) (I) Except as specified in subparagraph (II) of this paragraph (e), "health coverage plan" has the same meaning as set forth in section 10-16-102 (34).

(II) "Health coverage plan" does not include insurance arising out of the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S., or other similar law, automobile medical payment insurance, property and casualty insurance, or insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in any liability insurance policy or equivalent self-insurance.

(f) "Independent external review entity" means an entity that meets the requirements of this section, is accredited by a nationally recognized private accrediting organization, and is certified by the commissioner to conduct independent external reviews of adverse determinations by a carrier.

(g) (I) "Individual requesting an independent external review" means a covered person who:

(A) Has gone through at least one of the internal appeals review levels offered by a carrier and established pursuant to section 10-16-113 and has requested an independent external review of a carrier's decision to uphold an adverse determination; or

(B) Has pursued an expedited review of an adverse determination.

(II) "Individual requesting an independent external review" also includes the designated representative of an individual requesting an independent external review.

(h) "Medical and scientific evidence" includes the following sources:

(I) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(II) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the national institute of health's national library of medicine for indexing in index medicus, excerpta medicus ("EMBASE"), medline, and MEDLARS database of health services technology assessment research ("HSTAR");

(III) Medical journals recognized by the United States secretary of health and human services, pursuant to section 1861 (t)(2) of the federal "Social Security Act", 42 U.S.C. sec. 1395x;

(IV) The following standard reference compendia:

(A) The American hospital formulary service-drug information;

(B) The American medical association drug evaluation;

(C) The American dental association accepted dental therapeutics; and

(D) The United States pharmacopoeia - drug information.

(V) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal agency for health care policy and research, national institutes of health, the national cancer institute, the national academy of sciences, the health care financing administration, the congressional office of technology assessment, and the national board recognized by the national institutes of health for the purpose of evaluating the medical value of health services.

(3) Carriers shall make available an independent external review process that meets the requirements of this section. The carrier shall pay the cost of an independent external review. There is no restriction on the minimum dollar amount of a claim for it to be eligible for external review.

(4) (a) To qualify for certification by the commissioner as an independent external review entity, the entity must meet the following requirements:

(I) The independent external review entity shall ensure that cases are reviewed by expert reviewers knowledgeable about the recommended treatment or service through the expert reviewers' actual, current clinical experience and who have appropriate expertise in the same or similar specialties as would typically manage the case being reviewed.

(II) The independent external review entity shall ensure that the decision is based upon a case review that includes a review of the medical records of the individual requesting an independent external review and a review of relevant medical and scientific evidence.

(III) The independent external review entity shall have a quality assurance procedure that ensures the timeliness and quality of the reviews conducted pursuant to this section, the qualifications and independence of the expert reviewers, and the confidentiality of medical records and review materials.

(IV) The independent external review entity shall maintain patient confidentiality pursuant to Colorado and federal law.

(b) In addition to the requirements set forth in paragraph (a) of this subsection (4), the commissioner shall certify only an independent external review entity that:

(I) Is not a subsidiary of, or owned or controlled by, a carrier, a trade association of carriers, or a professional association of health-care providers;

(II) Maintains documentation available for review by the division upon request that includes the following:

(A) The names of all stockholders and owners of more than five percent of stock or options;

(B) The names of all holders of bonds or notes in amounts in excess of one hundred thousand dollars;

(C) The names of all corporations and organizations that the independent external review entity controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's business activities;

(D) The names of all directors, officers, and executives of the independent external review entity and a statement regarding any relationship the directors, officers, or executives may have with any carrier;

(III) Does not have any material professional, family, or financial conflict of interest with:

(A) The carrier or any officer, director, or executive of the carrier. This requirement does not prohibit a physician or qualified health-care professional who contracts with the carrier as a participating provider from serving on a review panel of the independent external review entity if the physician or qualified health-care professional meets the requirements of paragraph (d) of subsection (2) of this section. If a participating provider serves on the panel reviewing the case of an individual requesting an independent external review, the review entity shall notify the individual requesting an independent external review that a health-care professional serving on the review panel has a contract as a participating provider with the carrier.

(B) The physician or physician's medical group that treated the individual requesting an independent external review;

(C) The institution at which the treatment or service would be provided;

(D) The development or manufacture of the principal drug, device, procedure, treatment, or service proposed for the individual requesting an independent external review whose treatment is under review; or

(E) The individual requesting an independent external review.

(c) Nothing in subparagraph (III) of paragraph (b) of this subsection (4) includes affiliations that are limited to staff privileges at a health-care institution.

(d) The commissioner shall promulgate rules as necessary for the certification of independent external review entities under this section. The commissioner may deny, suspend, or revoke the certification of an independent external review entity that does not comply with the requirements of this section. The commissioner may contract with any person or entity to develop the certification rules and for implementation and administration of the certification program.

(5) Upon receipt of a request from an individual requesting an independent external review of a denial, the carrier shall contact the division. The division or its contractor shall

inform the carrier of the name of the independent external review entity to which the appeal should be sent.

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

(7) An individual requesting an independent external review shall make the request within four months after receiving notification of the denial of the individual's internal appeal of an adverse determination. In the internal appeal denial notification, the carrier shall inform the individual of his or her right to an independent external review. An individual requesting an independent external review shall notify the carrier if the individual requests an expedited review. An individual requesting an expedited independent external review may obtain such external review concurrently with an expedited internal appeal request under section 10-16-113.

(8) An individual may request an independent external review or an expedited independent external review involving a denial of coverage of a recommended or requested medical service that is experimental or investigational if the individual's treating physician certifies in writing that the recommended or requested health-care service or treatment that is the subject of the denial would be significantly less effective if not promptly initiated. The individual's treating physician must certify in writing that at least one of the following situations applies:

(a) Standard health-care services or treatments have not been effective in improving the condition of the individual or are not medically appropriate for the individual; or

(b) There is no available standard health-care service or treatment covered by the carrier that is more beneficial than the recommended or requested health-care service, and the physician is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the individual's condition. The physician must certify that scientifically valid studies using accepted protocols demonstrate that the health-care service or treatment requested by the individual that is the subject of the denial is likely to be more beneficial to the individual than any available standard health-care services or treatments.

(8.5) An individual requesting an independent external review may request the review or an expedited review to determine if section 10-16-704 (3) or (5.5) applies to the items or services that were provided or may be provided to a covered person by an out-of-network provider or at an out-of-network facility.

(9) After receipt of a written request for an independent external review, the carrier shall notify the individual requesting an independent external review in writing. The notification must include descriptive information on the independent external review entity that the division or its contractor has selected to conduct the independent external review.

(10) (a) The carrier shall provide to the independent external review entity a copy of the following documents after the division or its contractor has selected an independent external review entity for the case:

(I) Any information submitted to the carrier, under the carrier's procedures, in support of the request for an independent external review, by an individual requesting the review or by the physician or other health-care professional of the individual seeking the review. The independent

external review entity shall maintain the confidentiality of any medical records submitted pursuant to this subsection (10).

(II) A copy of any relevant documents used by the carrier in making its adverse determination on the proposed service or treatment, and a copy of any denial letters issued by the carrier concerning the individual case under review. The carrier shall provide, upon request to the individual requesting an independent external review, all relevant information supplied to the independent external review entity that is not confidential or privileged under state or federal law concerning the individual case under review.

(III) The individual requesting an independent external review may submit additional information directly to the independent external review entity within five business days after the notification under subsection (9) of this section. The independent external review entity shall provide a copy of the information submitted by the individual to the carrier whose adverse determination is being reviewed within one business day after receipt of the information.

(b) The independent external review entity shall notify the individual requesting an independent external review, the physician or other health-care professional of the individual requesting an independent external review, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required or provided pursuant to this subsection (10). The individual requesting an independent external review or the physician or other health-care professional of the individual requesting an independent external review shall submit the additional information, or an explanation of why the additional information is not being submitted, to the independent external review entity and the carrier after the receipt of such a request.

(c) The carrier may determine that additional information provided by the individual requesting independent external review or the physician or other health-care professional of the individual requesting independent external review under subparagraph (III) of paragraph (a) and paragraph (b) of this subsection (10) justifies a reconsideration of its adverse determination, and a subsequent decision by the carrier to provide coverage terminates the independent external review upon notification in writing to the independent external review entity and the individual requesting an independent external review.

(11) (a) The independent external review entity shall submit the expert determination to the carrier, the individual requesting independent external review, and the physician or other health-care professional of the individual requesting an independent external review within forty-five calendar days after the independent external review entity has received a request for external review. In the case of an expedited review, the independent external review entity shall submit the determinations as expeditiously as possible and no more than seventy-two hours after the independent external review entity received a request for an expedited external review. If the notice of the determination in an expedited review is not made in writing, the independent external review entity shall provide written confirmation of the decision within forty-eight hours after the date the notice of decision is transmitted to the individual, the physician, or other health-care professional.

(b) The expert reviewer's determination must:

(I) Be in writing and state the reasons the requested treatment or service should or should not be covered;

(II) Specifically cite the relevant provisions in the health coverage plan documentation, the specific medical condition of the individual requesting an independent external review, and

the relevant documents provided pursuant to this section to support the expert reviewer's determination; and

(III) Be based on an objective review of relevant medical and scientific evidence.

(c) Determinations must also include:

(I) The titles and qualifying credentials of the persons conducting the review;

(II) A statement of the understanding of the persons conducting the review of the nature of the grievance and all pertinent facts;

(III) The rationale for the decision;

(IV) Reference to medical and scientific evidence and documentation considered in making the determination; and

(V) In cases involving a determination adverse to the individual requesting an independent external review, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.

(12) The determinations of the expert reviewer are binding on the carrier and on the individual requesting independent external review. A determination of the expert reviewer in favor of the individual requesting independent external review creates a rebuttable presumption in any subsequent action that the carrier's adverse determination was not appropriate. A determination of the expert reviewer in favor of the carrier creates a rebuttable presumption in any subsequent action that the carrier's adverse determination was appropriate.

(13) Where an expert determination is made in favor of the individual requesting an independent external review, the carrier shall provide coverage for the treatment and services required under this section subject to the terms and conditions applicable to benefits under the health coverage plan.

(14) An independent external review entity and an expert reviewer assigned by the independent external review entity to conduct a review pursuant to this section are immune from civil liability in any action brought by any person based upon the determinations made pursuant to this section. This subsection (14) does not apply to an act or omission of the independent external review entity that is made in bad faith or involves gross negligence.

(15) A carrier is not liable for damages arising from any act or omission of the independent external review entity.

(16) A carrier may require a surety bond to indemnify the carrier for the independent external review entity's noncompliance with this section.

(17) An independent external review entity shall maintain written records of reviews on all requests for external review for which it was assigned to conduct an external review for at least three years.

Source: L. 99: Entire section added, p. 1048, § 2, effective June 1, 2000. **L. 2005:** (2)(a)(I)(A) amended, p. 805, § 3, effective January 1, 2006. **L. 2013:** Entire section amended, (HB 13-1266), ch. 217, p. 961, § 20, effective May 13. **L. 2016:** (2)(f) amended, (SB 16-189), ch. 210, p. 756, § 15, effective June 6. **L. 2022:** (8.5) added, (HB 22-1284), ch. 446, p. 3133, § 1, effective August 10. **L. 2023:** (2)(a)(III) and (2)(a)(IV) amended and (2)(a)(V) added, (HB 23-1225), ch. 162, p. 709, § 10, effective August 7.

10-16-113.7. Reporting the denial of benefits to division. Each carrier shall report the number and outcome of second-level internal appeals pursuant to section 10-16-113 to the

division by February 1 of each year. On at least an annual basis, the division shall compile the information reported by each carrier along with the number and outcome of third-level external appeals of each health coverage plan and make such information available on the division website and for public inspection. The commissioner may specify the format in which the information shall be submitted by a carrier.

Source: L. 2005: Entire section added, p. 805, § 4, effective January 1, 2006.

10-16-114. Short title. (Repealed)

Source: L. 94: Entire section added, p. 742, § 1, effective January 1, 1995. **L. 2013:** Entire section repealed, (HB 13-1266), ch. 217, p. 978, § 27, effective May 13.

Editor's note: This section was relocated to § 10-16-116 (1) in 2013.

10-16-115. Definitions. (Repealed)

Source: L. 94: Entire section added, p. 742, § 1, effective January 1, 1995. **L. 2013:** Entire section repealed, (HB 13-1266), ch. 217, p. 978, § 27, effective May 13.

Editor's note: This section was relocated to § 10-16-116 (6) in 2013.

10-16-116. Catastrophic health insurance - coverage - premium payments - reporting requirements - definitions - short title - rules - repeal. (1) This section shall be known and may be cited as the "Colorado Catastrophic Health Insurance Coverage Act".

(2) (a) An employer may offer catastrophic health insurance to its employees pursuant to this section.

(b) Prior to January 1, 2025, employees who elect the coverage shall pay the cost of the insurance pursuant to subsection (5) of this section.

(c) This subsection (2)(c) and subsection (2)(b) of this section are repealed, effective December 31, 2028.

(3) Each catastrophic health insurance policy issued pursuant to this section must:

(a) Be issued to the employer unless issued as an individual plan pursuant to section 10-16-105.2 (1)(d);

(b) In order to be considered a qualified higher deductible plan for purposes of a medical savings account pursuant to section 39-22-504.7, C.R.S., or other provisions of state law, meet the requirements for a qualifying plan for a health savings account under federal law and have a minimum deductible of at least one thousand five hundred dollars but no more than two thousand two hundred fifty dollars for individual coverage or at least three thousand dollars but no more than four thousand five hundred dollars for family coverage;

(c) Offer coverage for the spouse or partner in a civil union and dependent children of the insured employee;

(d) Cover all employees who elect coverage and are not otherwise covered by medicare or another health insurance policy;

(e) For group coverage, cover an employee and eligible dependents regardless of health status;

(f) Be priced according to appropriate rating requirements for health benefit plans as specified by law;

(g) Provide a clearly written contract of coverage, including a list of procedures covered under the policy;

(h) Comply with requirements for health benefit plans specified in this article.

(4) When catastrophic health insurance is purchased pursuant to this section, the employer, at its option, may pay all or a part of the cost of the insurance.

(5) (a) Prior to January 1, 2025, if claiming an exclusion of premium payments for state income tax purposes pursuant to section 39-22-104.5, an employee shall elect to purchase catastrophic health insurance by signing a written election, which must be in the form prescribed by the executive director of the department of revenue and signed by the employee prior to the date the employer withholds the first contribution.

(b) Prior to January 1, 2025, an employer shall withhold the premium payments for catastrophic health insurance from the wages of an employee who has elected coverage pursuant to subsection (5)(a) of this section and shall remit the premiums to the insuring entity on the employee's behalf. All premiums collected by an employer are withheld from the employee's wages on a pretax basis pursuant to section 39-22-104.5.

(c) Prior to January 1, 2025, an employer withholding premium payments from an employee's wages pursuant to subsection (5)(b) of this section shall report the amount withheld to the department of revenue, pursuant to rules promulgated by the executive director of the department.

(d) This subsection (5) is repealed, effective December 31, 2028.

(6) As used in this section, unless the context otherwise requires:

(a) "Catastrophic health insurance" means insurance meeting the requirements set forth in subsection (3) of this section. The term does not include a catastrophic plan as defined in section 10-16-102 (10).

(b) "Dependent child" means an adopted or natural child of an employee who is:

(I) Under twenty-one years of age;

(II) Legally entitled to or the subject of a court order for the provision of proper or necessary subsistence, education, medical care, or any other care necessary for the individual's health, guidance, or well-being and who is not otherwise emancipated, self-supporting, married, or a member of the armed forces of the United States; or

(III) So mentally or physically incapacitated that the individual cannot provide for himself or herself.

(c) "Employee" means an individual who resides in this state and is employed by an employer.

(d) "Employer" means a person or entity employing one or more individuals in this state, excluding the federal government or businesses providing health insurance coverage through a self-insured plan that has benefits equal to or greater than a catastrophic health insurance plan set forth in this section.

Source: L. 94: Entire section added, p. 742, § 1, effective January 1, 1995; (2) amended, p. 1917, § 10, effective July 1. **L. 2000:** (2)(a), (2)(b), (2)(e), (2)(f), IP(2)(h), and (2)(h)(II)

amended and (2)(i) added, p. 171, § 1, effective January 1, 2001. **L. 2002:** (3) added, p. 1293, § 4, effective January 1, 2003. **L. 2004:** (1), (2)(a), (2)(b), (2)(d), (2)(g), (2)(h)(II), and (3) amended, p. 989, § 8, effective August 4. **L. 2007:** (3) amended, p. 451, § 4, effective January 1, 2008. **L. 2009:** (3) amended, (HB 09-1204), ch. 344, p. 1808, § 5, effective January 1, 2010. **L. 2013:** Entire section amended with relocations, (HB 13-1266), ch. 217, p. 970, § 21, effective May 13. **L. 2024:** (2) and (5) amended, (HB 24-1036), ch. 373, p. 2524, § 2, effective August 7.

Editor's note: Subsection (1) is similar to former § 10-16-114; subsection (4) is similar to former § 10-16-117 (1); subsection (5) is similar to former § 10-16-117 (2), (3), and (4); and subsection (6) is similar to former § 10-16-115, as those sections existed prior to 2013.

Cross references: For the legislative declaration contained in the 2009 act amending subsection (3), see section 1 of chapter 344, Session Laws of Colorado 2009. For the legislative declaration in HB 24-1036, see section 1 of chapter 373, Session Laws of Colorado 2024.

10-16-116.5. State innovation waiver for nonemployer catastrophic health plans - notice of decision by secretary - effect of secretary's decision - notice to revisor of statutes - definitions - rules - state measurement for accountable, responsive, and transparent (SMART) government act report - repeal. (Repealed)

Source: L. 2018: Entire section added, (SB 18-132), ch. 194, p. 1283, § 2, effective August 8.

Editor's note: Subsection (8) provided for the repeal of this section, effective January 1, 2023. (See L. 2018, p. 1283.)

10-16-117. Premium payments - pre-tax - election - reporting requirements. (Repealed)

Source: L. 94: Entire section added, p. 742, § 1, effective January 1, 1995. **L. 2004:** Entire section amended, p. 990, § 9, effective August 4. **L. 2013:** Entire section repealed, (HB 13-1266), ch. 217, p. 978, § 27, effective May 13.

Editor's note: This section was relocated to § 10-116 (4) and (5) in 2013.

10-16-118. Prohibition against preexisting condition exclusions. A carrier offering an individual or small employer health benefit plan in this state shall not impose any preexisting condition exclusion with respect to coverage under the plan.

Source: L. 94: Entire section added, p. 1913, § 9, effective July 1. **L. 97:** Entire section amended, p. 639, § 7, effective July 1. **L. 2002:** (1)(a)(I) amended, p. 1284, § 3, effective January 1, 2003; (1)(a)(I) amended, p. 1293, § 5, effective January 1, 2003. **L. 2013:** Entire section R&RE, (HB 13-1266), ch. 217, p. 972, § 22, effective May 13.

Cross references: For the legislative declaration contained in the 1997 act amending this section, see section 1 of chapter 154, Session Laws of Colorado 1997.

10-16-119. Requirements for excess loss or stop-loss health insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act" - data collection 2013-18 - rules. (1) Any entity issuing excess loss insurance shall file all policy forms with the division and certify compliance with the provisions of this title.

(2) All excess loss insurance shall be issued to cover the employer's liability under the employer's self-insured obligation. Excess loss insurance shall meet the following requirements:

(a) The policy shall only be issued to insure an employer and not the employer's employees;

(b) Payment by the issuer of the insurance shall only be made to the employer and not the employees or providers;

(c) Commencing with policies issued or renewed on and after January 1, 2003, the minimum retention to the employer shall be no less than fifteen thousand dollars per person per plan year with a minimum one hundred twenty percent of expected claims aggregate.

(3) Repealed.

Source: L. 94: Entire section added, p. 1913, § 9, effective July 1. **L. 2002:** (2)(c) amended, p. 1293, § 6, effective January 1, 2003. **L. 2013:** (3) added, (HB 13-1290), ch. 339, p. 1975, § 1, effective July 1.

Editor's note: Subsection (3)(d) provided for the repeal of subsection (3), effective September 1, 2019. (See L. 2013, p. 1976.)

10-16-119.5. Stop-loss health insurance for small employers of not more than fifty employees - requirements - definitions - rules. (1) Notwithstanding section 10-16-119, the purpose of this section is to establish criteria for the issuance of stop-loss health insurance policies to any person, firm, corporation, partnership, or association actively engaged in business that employed an average of at least one but not more than fifty eligible employees on business days during the immediately preceding calendar year. This section does not impose any requirement or duty on any person other than an insurer offering stop-loss health insurance policies to any person, firm, corporation, partnership, or association actively engaged in business that employed an average of at least one but not more than fifty eligible employees on business days during the immediately preceding calendar year or treat any stop-loss health insurance policy as a direct policy of health insurance.

(2) An insurer shall not issue a stop-loss health insurance policy to any person, firm, corporation, partnership, or association actively engaged in business that employed an average of at least one but not more than fifty eligible employees on business days during the immediately preceding calendar year that:

(a) Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars;

(b) Has an annual aggregate attachment point lower than the greater of:

(I) One hundred twenty percent of expected claims; or

(II) Twenty thousand dollars;

(c) Provides direct coverage of health-care expenses of an individual;

(d) Varies by individual within the group the annual attachment point for claims incurred per individual; or

(e) Excludes any employee or eligible dependent from the stop-loss health insurance coverage.

(3) The commissioner may, by rule, change the dollar amounts in subsection (2) of this section based upon changes in the medical components of the Denver-Aurora-Lakewood consumer price index or its applicable predecessor or successor index. Any change in these dollar amounts must be made at least six months prior to the effective date of the change.

(4) An insurer that issues one or more stop-loss health insurance policies to any person, firm, corporation, partnership, or association actively engaged in business that employed an average of at least one but not more than fifty eligible employees on business days during the immediately preceding calendar year shall file with the commissioner annually an actuarial certification certifying that the insurer is in compliance with this section. The certification must be in a form and manner and contain information as required by the commissioner.

(5) For each stop-loss health insurance policy delivered, issued for delivery, or entered into, the insurer shall prepare a separate exhibit to be given to the insured with the policy containing at least the following information:

(a) The complete costs for the stop-loss health insurance policy;

(b) The date on which the stop-loss health insurance policy takes effect and terminates, including renewability provisions;

(c) The aggregate attachment point and the specific attachment point for the stop-loss health insurance policy;

(d) Any limitations on coverage;

(e) An explanation of monthly accommodation and disclosure about any monthly accommodation features included in the stop-loss health insurance policy; and

(f) A description of terminal liability funding, including:

(I) Costs of processing claims before and after the termination of the policy; and

(II) Maximum claims liability to the employer.

(6) As used in this section:

(a) "Actuarial certification" means a written statement by a member of the American academy of actuaries, or by another individual acceptable to the commissioner, that an insurer is in compliance with this section, based upon the individual's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the insurer in establishing attachment points and other applicable determinations in conjunction with the provision of stop-loss health insurance coverage.

(b) "Attachment point" means the claims amount incurred by an insured group beyond which the insurer incurs a liability for payment.

(c) "Expected claims" means the amount of claims that, in the absence of a stop-loss health insurance policy or other insurance, are projected to be incurred by an insured group through its health plan.

Source: L. 2013: Entire section added, (HB 13-1290), ch. 339, p. 1976, § 2, effective January 1, 2014. **L. 2018:** (3) amended, (HB 18-1375), ch. 274, p. 1695, § 4, effective May 29.

10-16-120. Legislative review of requirements for guaranteed issue of basic and standard health benefit plans. (Repealed)

Source: L. 94: Entire section added, p. 1913, § 9, effective July 1. **L. 96:** (1) amended, p. 1230, § 52, effective August 7. **L. 97:** (1) amended, p. 1478, § 25, effective June 3. **L. 2001:** (2) amended, p. 1167, § 2, effective July 1. **L. 2006:** Entire section repealed, p. 1077, § 4, effective July 1.

Cross references: For the legislative declaration contained in the 2006 act repealing this section, see section 1 of chapter 236, Session Laws of Colorado 2006.

10-16-121. Required contract provisions in contracts between carriers and providers - definitions. (1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan must make provisions for the following requirements:

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

(b) (I) The contract must contain a provision that states the carrier may not take an adverse action against a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier's decision or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients.

(II) The contract between a carrier and the provider must state that the carrier may not take an adverse action against a provider because the provider, acting in good faith:

(A) Communicates with a public official or other person concerning public policy issues related to health-care items or services;

(B) Files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of the carrier the provider believes might negatively affect the quality of, or access to, patient care;

(C) Provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of any provision of this section;

(D) Reports what the provider believes to be a violation of law to an appropriate authority; or

(E) Participates in any investigation into a violation or possible violation of any provision of this section.

(c) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts must require such entity to comply with section 10-16-106.5 (3), (4), and (5).

(d) The contract must contain a provision that the provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers in the

health plan for covered benefits so long as the provider making the referral adheres to the carrier's or the carrier's intermediary's utilization review policies and procedures.

(e) The contract must contain a provision that states the carrier shall not take an adverse action against a provider or provide financial incentives or subject the provider to financial disincentives based solely on a patient satisfaction survey or other method of obtaining patient feedback relating to the patient's satisfaction with pain treatment.

(f) (I) A provision that prohibits the carrier from taking an adverse action against a provider or subjecting the provider to financial disincentives based solely on the provider's provision of, or assistance in the provision of, a legally protected health-care activity, as defined in section 12-30-121 (1)(d), in this state, so long as the care provided did not violate Colorado law.

(II) As used in this subsection (1)(f), "adverse action" means refusing or failing to pay a provider for otherwise covered services as defined in the applicable health benefit plan.

(2) Nothing in subsection (1) of this section shall be construed to prohibit a carrier from:

(a) Including in its provider contracts a provision that precludes a provider from making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature that is false or maliciously critical of the carrier and calculated to injure such carrier; or

(b) Terminating a contract with a provider because such provider materially misrepresents the provisions, terms, or requirements of a carrier's products; or

(c) Terminating a contract with a provider pursuant to a contract provision that allows either party to the contract to terminate the contract without cause pursuant to specific notice requirements that are the same for both parties.

(3) Each contract between a carrier and an intermediary shall contain a provision requiring that the underlying contract authorizing the intermediary to negotiate and execute contracts with carriers, on behalf of the providers, shall comply with the requirements of subsection (1) of this section.

(4) The commissioner shall not act to arbitrate, mediate, or settle disputes between a carrier, its intermediaries, or a provider network arising under or by reason of a provider contract or its termination. Existing dispute resolution mechanisms available in contract law shall be used to resolve such disputes. Notwithstanding any provision of law to the contrary, the commissioner is not prohibited from enforcing the applicable provisions of this article.

(5) The commissioner shall, after notice and hearing, promulgate reasonable regulations as are necessary or proper to carry out the requirements of this section.

(6) No contract between a carrier and a provider or its representative or between a carrier and an intermediary that concerns the delivery, provision, payment, or offering of care or services covered by a managed care plan shall be issued, renewed, amended, or extended in this state after January 1, 1997, unless it complies with the requirements of this section.

(7) (a) A provider who is aggrieved by a violation of this section may bring an action for injunctive relief in a court of competent jurisdiction and may seek recovery of reasonable court costs. This section does not change the standards for obtaining injunctive relief.

(b) If a court deems an action frivolous, the court may award costs to the defendant.

(8) As used in this section:

(a) "Adverse action" means a decision by a carrier to terminate, deny, or otherwise condition a provider's participation in one or more provider networks, including a decision pertaining to participation in a narrow network or allocation within a tiered network.

(b) "Narrow network" means a reduced or selective provider network that is a subgroup or subdivision of a larger provider network and from which providers who participate in the larger network may be excluded.

(c) "Tiered network" means a provider network in which:

(I) Providers are assigned to, or placed in, different benefit tiers, as determined by tiering; and

(II) Patients receive benefits and pay the copayment, coinsurance, or deductible amounts that are associated with the benefit tier to which the provider from whom services were received is assigned.

(d) "Tiering" means a system that compares, rates, ranks, tiers, or classifies a provider's performance, quality of care, or cost of care against objective standards or against the practice or performance of other health-care providers. "Tiering" includes quality improvement programs, pay-for-performance programs, public reporting on health-care provider performance or ratings, and the use of tiered or narrowed networks.

Source: L. 96: Entire section added, p. 569, § 3, effective July 1. **L. 99:** (1)(c) added, p. 1142, § 3, effective January 1, 2000. **L. 2000:** (1)(d) added, p. 1064, § 2, effective August 2, 2000. **L. 2003:** (4) amended, p. 2494, § 2, effective June 5. **L. 2017:** (1) amended and (7) and (8) added, (HB 17-1173), ch. 120, p. 421, § 1, effective July 1. **L. 2018:** (1)(e) added, (HB 18-1007), ch. 225, p. 1431, § 2, effective January 1, 2019. **L. 2023:** (1)(f) added, (SB 23-188), ch. 68, p. 242, § 3, effective April 14.

Cross references: For the legislative declaration contained in the 1996 act enacting this section, see section 1 of chapter 122, Session Laws of Colorado 1996. For the legislative declaration contained in the 2000 act enacting subsection (1)(d), see section 1 of chapter 238, Session Laws of Colorado 2000. For the legislative declaration in SB 23-188, see section 1 of chapter 68, Session Laws of Colorado 2023.

10-16-121.3. Limitations on provisions in contracts between carriers and licensed health-care providers - methods of payment - fees - definitions. (1) As used in this section, unless the context otherwise requires:

(a) "Billing service" means a person or entity that contracts with a licensed health-care provider to:

(I) Process bills for health-care services provided by the licensed health-care provider; and

(II) Pursuant to the terms of the contract, submit bills, request reconsideration of payments, and receive payments or reimbursements for health-care services provided by the licensed health-care provider.

(b) "Contract" means a contract between a carrier and a licensed health-care provider for the provision of health-care services to covered persons under a health coverage plan issued by the carrier.

(c) "Health-care electronic funds transfers and remittance advice transaction" has the same meaning as defined in 45 CFR 162.1601 and incorporates the standards described in 45 CFR 162.1602.

(2) In a contract entered into, amended, or renewed on or after August 7, 2023, the carrier shall:

(a) Offer at least one method of payment to the licensed health-care provider that does not require an associated fee charged to the health-care provider; and

(b) Not restrict the method or form of payment to the licensed health-care provider so that the only acceptable payment method is a credit card payment.

(3) If a carrier initiates a payment to a licensed health-care provider using, or changes the payment method to, electronic funds transfer payments, including virtual credit card payments, the carrier shall:

(a) Notify the licensed health-care provider if any fee is associated with a particular payment method;

(b) Advise the licensed health-care provider of the available payment methods and provide clear instructions to the licensed health-care provider as to how to select an alternative payment method; and

(c) With each payment, remit an explanation of benefits.

(4) For any contract that is in effect on or before August 7, 2023, or that is entered into, amended, or renewed on or after August 7, 2023, a carrier that initiates a payment to a licensed health-care provider using, or changes the payment method to, a health-care electronic funds transfers and remittance advice transaction shall not charge a fee solely to transmit the payment to the licensed health-care provider unless the licensed health-care provider consents to the fee. A licensed health-care provider's billing service may charge a reasonable fee related to transaction management, data management, portal services, or other value-added services above and beyond the bank transmittal when transmitting an electronic funds transfer.

(5) The commissioner has the authority to enforce this section and impose a penalty or remedy against a person who violates this section.

Source: L. 2023: Entire section added, (HB 23-1116), ch. 59, p. 208, § 1, effective August 7.

10-16-121.5. Prohibited contract provisions in contracts between carriers and providers for dental services - definition. (1) A contract between a carrier and a dentist licensed to practice under article 220 of title 12 must not require, directly or indirectly, that a dentist who is a participating provider provide services to a covered person at a fee set by, or subject to the approval of, the carrier unless:

(a) The services are covered services under the person's policy; and

(b) The carrier provides payment for the services under the person's policy in an amount that is reasonable and not nominal or de minimis.

(2) The dentist may charge the covered person for noncovered items or services in any amount determined by the dentist and agreed to by the patient that is equal to, or less than, the usual and customary amount that the dentist charges individuals who do not have coverage for such items and services.

(3) If the commissioner determines that a carrier has not complied with this section, the commissioner shall institute a corrective action plan that the carrier shall follow or may use any of the commissioner's enforcement powers to obtain the carrier's compliance with this section.

(4) For purposes of this section, "covered services" means dental care services for which reimbursement is available under a covered person's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other contractual limitations.

Source: L. 2017: Entire section added, (SB 17-190), ch. 147, p. 492, § 2, effective August 9. **L. 2019:** IP(1) amended, (HB 19-1172), ch. 136, p. 1654, § 45, effective October 1.

Cross references: For the legislative declaration in SB 17-190, see section 1 of chapter 147, Session Laws of Colorado 2017.

10-16-121.7. Prohibited contract provisions in contracts between carriers and eye care providers - definitions. (1) A carrier or entity that offers a vision care plan shall not require that an eye care provider with whom the carrier or entity contracts:

(a) Provide services or materials to a covered person at a fee set by, or subject to the approval of, the carrier or entity unless the services or materials are covered services or covered materials under the covered person's vision care plan and the amount of coverage is neither nominal nor de minimis;

(b) Charge a covered person for a noncovered service or noncovered materials in an amount less than the usual and customary amount that the eye care provider charges individuals who do not have coverage for such materials and services; or

(c) Participate, as a condition of participation in a vision care plan, in any of the carrier's or entity's other vision plan networks.

(2) A carrier or entity shall not change the terms of the contract between the carrier or entity and an eye care provider without communication with the eye care provider.

(3) If the commissioner determines that a carrier or entity has not complied with this section, the commissioner shall do one or both of the following:

(a) Institute a corrective action plan for the carrier to follow;

(b) Use any of the commissioner's enforcement powers to obtain the carrier's or entity's compliance with this section.

(4) For purposes of this section:

(a) "Covered materials" means materials for which reimbursement is available under a covered person's vision care plan, or for which reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other contractual limitations.

(b) "Covered services" means eye care provider services for which reimbursement is available under a covered person's vision care plan, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other contractual limitations.

(c) "Eye care provider" means:

(I) An optometrist licensed to practice under article 275 of title 12; or

(II) An ophthalmologist licensed to practice under article 240 of title 12.

(d) "Materials" means ophthalmic devices including lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatus, prisms, lens treatments and coatings, contact lenses, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye.

(e) "Usual and customary amount" means an amount established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.

(f) "Vision care plan" means:

(I) A vision care insurance policy or contract that provides vision benefits to a covered person; and

(II) A vision discount plan that provides discounts to vision benefits to a covered person.

(5) This section does not apply to an entity offering a vision discount plan to the entity's members if the entity is not primarily engaged in the business of offering vision care plans.

Source: L. 2018: Entire section added, (HB 18-1012), ch. 79, p. 665, § 1, effective January 1, 2019. **L. 2019:** (4)(c) amended, (HB 19-1172), ch. 136, p. 1655, § 46, effective October 1.

10-16-122. Access to prescription drugs. (1) Except as provided in section 25.5-5-406.1 (1)(s), any pharmacy benefit management firm or intermediary whose contract with a carrier includes an open network shall allow participation by each pharmacy provider in the contract service area. If a pharmacy benefit management firm or intermediary offers an open network, the pharmacy benefit management firm or intermediary may offer such network on a regional or local basis.

(2) For purposes of this section, "open network" means any pharmacy network created by a pharmacy benefit management firm or intermediary through a contracting process with pharmacy providers that does not include competitive bidding and allows participation by any pharmacy provider that agrees to the terms and conditions of the contract offered by the pharmacy benefit management firm or intermediary.

(3) A pharmacy benefit management firm or intermediary shall not be prohibited from contracting with exclusive pharmacy networks if, sixty days before the termination or effective date of an exclusive pharmacy network contract between the pharmacy providers and the pharmacy benefit management firm or intermediary, notice of such termination or of the effective date of an exclusive pharmacy network contract is published in one or more newspapers of general circulation in the affected contract service area. Notice shall include information about where in Colorado a copy of the pharmacy provider selection criteria may be obtained.

(4) (a) No pharmacy benefit manager or carrier offering a managed care plan shall transfer or request that a pharmacy provider transfer the prescription or prescriptions of a covered person or subscriber, wholly or in part, to a different participating pharmacy provider than the provider selected by the covered person or subscriber unless one or more of the following conditions have been met:

(I) The participating pharmacy provider to whom the covered person or subscriber's prescription is to be transferred or the carrier or pharmacy benefit manager has obtained a document, signed by the covered person or subscriber, that contains a clear, conspicuous, and unequivocal request by the covered person or subscriber for a change of provider;

(II) The participating pharmacy provider carrier or pharmacy benefit manager to whom the covered person or subscriber's prescription is to be transferred has obtained the covered person or subscriber's oral authorization for the transfer and is able to furnish proof of such authorization through verification by an independent third party or an electronic record; or

(III) The pharmacy provider's participation in the pharmacy network of the carrier or pharmacy benefit manager has changed and the pharmacy provider selected by the covered person or subscriber is no longer a participating provider in the network, provided that the covered person or subscriber has been notified of the proposed transfer of pharmaceutical care services and is given an opportunity to affirmatively select a participating pharmacy provider other than the proposed transferee.

(b) Nothing in this subsection (4) shall require a carrier offering a managed care plan or a pharmacy benefit manager to pay for pharmaceutical benefits received from a nonparticipating provider.

Source: L. 98: Entire section added, p. 1188, § 1, effective August 5. **L. 2001:** (4) added, p. 1230, § 2, effective January 1, 2002. **L. 2006:** (1) amended, p. 1999, § 35, effective July 1. **L. 2013:** (1) amended, (HB 13-1266), ch. 217, p. 988, § 48, effective May 13. **L. 2018:** (1) amended, (HB 18-1431), ch. 313, p. 1891, § 8, effective August 8.

10-16-122.1. Contracts between PBMs and pharmacies - carrier submit list of PBMs - PBM registration - fees - prohibited practices - exception - rules - enforcement - short title - definitions. (1) The short title of this section is the "Pharmacy Fairness Act".

(2) (a) Starting in 2022, each carrier shall submit to the commissioner, contemporaneously with its rate filing pursuant to section 10-16-107 and in a form and manner specified by the commissioner by rule, a list of all pharmacy benefit managers the carrier contracts with or otherwise uses for claims processing services or other prescription drug or device services under health coverage plans the carrier offers.

(b) The list of PBMs submitted to the commissioner pursuant to this subsection (2) is considered proprietary and confidential information and is not subject to disclosure under the "Colorado Open Records Act", part 2 of article 72 of title 24.

(2.5) (a) Starting in 2024, a person shall not establish or operate as a PBM in this state unless the person has registered with the commissioner in accordance with this subsection (2.5) and commissioner rules. Notwithstanding the definition of a PBM in section 10-16-102 (49), this registration requirement applies to all PBMs doing business in this state, including a PBM that is not directly connected with a carrier.

(b) (I) The commissioner shall establish, by rule, the form and manner for a person to register with the commissioner and shall charge application and renewal fees as established by rule. The commissioner shall set registration fees at amounts that are commensurate with the amounts of registration fees assessed in other states.

(II) The commissioner may deny a registration to a PBM; suspend, revoke, or refuse to issue, continue, or renew the registration of a PBM; or issue a cease-and-desist order to a PBM

if, after notice to the PBM and after a hearing held in accordance with sections 24-4-104 and 24-4-105, the commissioner finds that the PBM, or an officer, director, or employee of the PBM, has:

(A) Made a material misstatement, misrepresentation, or omission in a registration or registration renewal application;

(B) Fraudulently or deceptively obtained or attempted to obtain a registration or renewal of a registration;

(C) In connection with the administration of prescription drug benefits management services, committed fraud or engaged in illegal or dishonest activities; or

(D) Violated any provision of this title 10.

(III) A determination of the commissioner is a final agency action subject to judicial review pursuant to section 24-4-106.

(c) The commissioner shall transmit any fees collected pursuant to this subsection (2.5) to the state treasurer for deposit in the division of insurance cash fund created in section 10-1-103 (3). The commissioner shall use the fees collected pursuant to this subsection (2.5) to fund the division's costs in administering and enforcing this subsection (2.5) and the requirements and prohibitions on the conduct and actions of PBMs as specified in this article 16.

(3) A PBM or the representative of a PBM shall not:

(a) (I) With regard to individual and group health benefit plans, preclude covered persons from accessing prescription drug benefits under the health benefit plan at an in-network retail pharmacy unless:

(A) The FDA has restricted distribution of the prescription drug; or

(B) The prescription drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(II) A health benefit plan may impose a different cost-sharing amount for obtaining a covered prescription drug at a retail pharmacy, but all cost sharing must count towards the plan's annual limitation on cost sharing specified in 45 CFR 156.130 and must be accounted for in the plan's actuarial value calculated under 45 CFR 156.135.

(b) Charge a pharmacy or pharmacist a fee related to the adjudication of a pharmacist services claim, other than a one-time, reasonable fee, not to exceed the lesser of twenty-five percent of the pharmacy dispensing fee or twenty-five cents, for receipt and processing of the same pharmacist services claim;

(c) Require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements applicable to similarly situated PBM-affiliated pharmacies within the same PBM network; or

(d) (I) Prohibit a rural independent pharmacy from using a private courier or a delivery service to deliver a prescription drug to a patient; or

(II) Require a rural independent pharmacy to obtain consent from the PBM to use a private courier or delivery service to deliver a prescription drug to a patient.

(4) This section does not apply to the administration or management of the drug assistance program authorized pursuant to section 25-4-1401.

(4.5) With regard to the requirements of this section applicable to PBMs, the commissioner has the authority to enforce this section and to impose a penalty or other remedy against a PBM that fails to comply with this section.

(4.7) The commissioner may adopt rules to implement and enforce this section.

(5) As used in this section and section 10-16-122.9, unless the context otherwise requires:

(a) "Claims processing services" means the administrative services performed in connection with processing and adjudicating claims related to pharmacist services, which services include:

(I) Receiving payments for pharmacist services; or

(II) Making payments to pharmacies or pharmacists for pharmacist services.

(b) "Other prescription drug or device services" means services, other than claims processing services, provided directly or indirectly and either in connection with or separate from claims processing services. The term includes:

(I) Managing or participating in incentive programs or arrangements for pharmacist services;

(II) Negotiating or entering into contractual arrangements with pharmacies or pharmacists;

(III) Developing formularies;

(IV) Designing prescription drug benefits programs; and

(V) Advertising or promoting services.

(c) "PBM-affiliated pharmacy" means a pharmacy or pharmacist that, either directly or indirectly through one or more intermediaries, owns or controls or is owned or controlled by a PBM.

(d) "PBM network" means a network of pharmacies or pharmacists that are offered an agreement or contract to provide pharmacist services for a health benefit plan.

(e) "Pharmacist" has the same meaning as set forth in section 12-280-103 (35).

(f) "Pharmacist services" means products, goods, and services provided as a part of the practice of pharmacy, as defined in section 12-280-103 (39).

(g) "Pharmacy" has the same meaning as set forth in section 12-280-103 (43).

Source: L. 2021: Entire section added, (HB 21-1297), ch. 452, p. 2992, § 3, effective July 6. **L. 2023:** (2.5), (4.5), and (4.7) added, (HB 23-1227), ch. 160, p. 694, § 1, effective August 7. **L. 2025:** IP(3) amended and (3)(d) added, (HB 25-1222), ch. 259, p. 1328, § 3, effective August 6.

Editor's note: Section 8(2) of chapter 259 (HB 25-1222), Session Laws of Colorado 2025, provides that the act changing this section applies to conduct occurring on or after August 6, 2025.

Cross references: For the legislative declaration in HB 21-1297, see section 1 of chapter 452, Session Laws of Colorado 2021. For the legislative declaration in HB 25-1222, see section 1 of chapter 259, Session Laws of Colorado 2025.

10-16-122.3. Pharmacy benefit management firm payments - retroactive reduction prohibited - enforcement - rules - dispensing fees - definitions. (1) (a) A pharmacy benefit management firm shall not reimburse a pharmacy in an amount less than the amount that the pharmacy benefit management firm reimburses any affiliate for the same pharmacy services.

(b) This subsection (1) does not prohibit a pharmacy benefit management firm from reimbursing an affiliate for satisfying the terms of a performance-based contract.

(1.5) **[*Editor's note: Subsection (1.5) is effective January 1, 2026.*]** On and after January 1, 2026, a pharmacy benefit management firm shall reimburse a rural independent pharmacy for a prescription drug in an amount not less than the national average drug acquisition cost for the dispensed prescription drug ingredients and a dispensing fee. If the national average drug acquisition cost is not available at the time a prescription drug is administered or dispensed, a pharmacy benefit management firm shall not reimburse in an amount that is less than the wholesale acquisition cost of the prescription drug.

(2) (a) A contract or agreement, including a performance-based or value-based contract or agreement, between a pharmacy benefit management firm and a pharmacy or a pharmacy services administrative organization with respect to prescription drug benefits administered or managed by the pharmacy benefit management firm must provide that after the date the pharmacy benefit management firm receives a clean claim submitted by a pharmacy, the pharmacy benefit management firm shall not retroactively reduce payment on the claim after the point of sale except as the result of an audit conducted in accordance with section 10-16-122.5.

(b) Nothing in this subsection (2) prohibits a pharmacy benefit management firm from retroactively increasing a payment to a pharmacy pursuant to a written agreement between the pharmacy benefit management firm and the pharmacy or making adjustments to claims in the case of a clerical error.

(3) Each carrier that contracts with a pharmacy benefit management firm to manage or administer prescription drug benefits on the carrier's behalf shall include in a new, amended, or renewed contract with the pharmacy benefit management firm a requirement that the pharmacy benefit management firm comply with this section. The carrier shall annually audit the pharmacy benefit management firm to monitor and ensure compliance with this section.

(4) The division may promulgate rules to implement and enforce this section, including rules to establish the manner in which carriers and pharmacy benefit management firms are required to show compliance with this section.

(5) This section applies to contracts and agreements between pharmacy benefit management firms and pharmacies or pharmacy services administrative organizations in effect on or after January 1, 2021.

(5.5) With regard to the requirements of this section applicable to pharmacy benefit management firms, the commissioner has the authority to enforce this section and to impose a penalty or other remedy against a pharmacy benefit management firm that fails to comply with this section.

(6) As used in this section:

(a) "Affiliate" means a pharmacy that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefit management firm.

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. "Clean claim" does not include a claim based on fraud, waste, or abuse.

(b.3) **[*Editor's note: Subsection (6)(b.3) is effective January 1, 2026.*]** "Dispensing fee" means the reimbursement amount for costs associated with filling a prescription, as published for

rural pharmacies in 10 CCR 2505-10 sec. 8.800.13.M, as specified in the version of the rule adopted on July 12, 2024. On January 1, 2027, and on January 1 of every year thereafter, a pharmacy benefit management firm shall increase the amount of the dispensing fee by one percent to account for inflation.

(c) "Pharmacy" means an in-state or nonresident prescription drug outlet, as defined in section 12-280-103 (43); an other outlet, as defined in section 12-280-103 (32); a hospital satellite pharmacy, as defined in section 12-280-103 (20); or other setting, including a practitioner's office or clinic, where a practitioner, as defined in section 12-280-103 (40), dispenses prescription drugs to patients as authorized by section 12-280-120 (6).

Source: L. 2020: Entire section added, (HB 20-1078), ch. 98, p. 381, § 1, effective September 14. **L. 2023:** (4) amended and (5.5) added, (HB 23-1227), ch. 160, p. 695, § 2, effective August 7. **L. 2025:** (1.5) and (6)(b.3) added, (HB 25-1222), ch. 259, p. 1328, § 4, effective January 1, 2026.

Editor's note: Section 8(2) of chapter 259 (HB 25-1222), Session Laws of Colorado 2025, provides that the act changing this section applies to conduct occurring on or after January 1, 2026.

Cross references: For the legislative declaration in HB 25-1222, see section 1 of chapter 259, Session Laws of Colorado 2025.

10-16-122.4. Pharmacy benefits - formulary change prohibition - exceptions - enforcement - definition - rules. (1) (a) Starting in 2024, except as provided in subsection (2) of this section, a carrier or, if a carrier uses a PBM for claims processing services or other prescription drug or device services, as those terms are defined in section 10-16-122.1, under a health benefit plan offered by the carrier in the individual market, the PBM, or a representative of the carrier or the PBM, shall not modify or apply a modification to the current prescription drug formulary during the current plan year.

(b) As used in this subsection (1), "modify" or "modification" includes eliminating a particular prescription drug from the formulary or moving a prescription drug to a higher cost-sharing tier.

(2) A carrier offering a health benefit plan on the individual market in this state that includes a prescription drug benefit and uses a prescription drug formulary or list of covered drugs may:

(a) Remove a prescription drug from the prescription drug formulary or list of covered drugs, with notice to a covered person and the covered person's provider, if:

(I) The FDA issues an announcement, guidance, notice, warning, or statement concerning the prescription drug that calls into question the clinical safety of the prescription drug; or

(II) The prescription drug is approved by the FDA for use without a prescription;

(b) Move a prescription drug from a prescription drug cost-sharing tier that imposes a lesser copayment or deductible for the prescription drug to a cost-sharing tier that imposes a greater copayment or deductible for the prescription drug if the carrier adds to the prescription drug formulary or list of covered drugs a generic prescription drug or biosimilar drug that is:

(I) Approved by the FDA for use as a therapeutic equivalent; and

(II) In a prescription drug cost-sharing tier that imposes a copayment or deductible for the generic prescription drug or biosimilar drug that is less than the copayment or deductible that is imposed for the brand-name prescription drug in the cost-sharing tier to which the brand-name prescription drug is moved; or

(c) Remove a prescription drug from the prescription drug formulary or list of covered drugs, or move a prescription drug to a higher cost-sharing tier, with advance notice to a covered person and the covered person's provider, if:

(I) The prescription drug has a wholesale acquisition cost greater than five hundred dollars at the start of the benefit year and the carrier's net cost increases by fifteen percent or more during that benefit year; and

(II) The prescription drug will be replaced on the formulary with a therapeutically equivalent generic or multi-source brand-name drug, an interchangeable biologic, or biosimilar drug at a lower cost to the enrollee.

(3) Prior to removing a drug from a formulary pursuant to this section, the carrier must attest and demonstrate to the division, in a form and manner determined by the commissioner by rule, that it has complied with the requirements of this section and has provided advanced notice to its enrollees.

(4) This section does not prohibit a carrier from adding a prescription drug to a prescription drug formulary or list of covered drugs at any time.

(5) The commissioner may promulgate rules to implement and enforce this section.

(6) With regard to the requirements of this section applicable to PBMs, the commissioner has the authority to enforce this section and to impose a penalty or other remedy against a PBM that fails to comply with this section.

Source: L. 2022: Entire section added, (HB 22-1370), ch. 184, p. 1229, § 2, effective August 10. **L. 2023:** (6) added, (HB 23-1227), ch. 160, p. 695, § 3, effective August 7.

Editor's note: Subsection (3) was numbered as subsection (2)(d) in House Bill 22-1370 but was renumbered on revision, resulting in the renumbering of subsections (3) and (4) in House Bill 22-1370 to subsections (4) and (5), respectively.

10-16-122.5. Pharmacy benefit manager - audit of pharmacies - time limits on on-site audits - enforcement - rules. (1) A pharmacy benefit manager, a carrier, or an entity acting on behalf of a pharmacy benefit manager or a carrier that audits a pharmacy shall:

(a) Give the pharmacy at least seven days' written notice prior to commencing an audit;

(b) Conduct the audit by or in consultation with a licensed pharmacist to the extent the audit requires the application of clinical or professional judgment;

(c) Not use extrapolation or other statistical expansion techniques in calculating the amount of a recoupment or penalty resulting from an audit of a pharmacy;

(d) Allow the pharmacy to produce additional claims documentation using any commercially reasonable method, including facsimile, mail, or electronic claims submission, if an audit results in the dispute or denial of a claim;

(e) Establish a written appeals process that includes procedures to allow a pharmacy to appeal to the pharmacy benefit manager or the carrier the preliminary reports resulting from the audit and any resulting recoupment or penalty;

(f) Not subject a pharmacy to the recoupment of funds when an audit results in the identification of a clerical error in a required document or record unless the error results in actual financial harm to the pharmacy benefit manager, a health benefit plan providing prescription drug benefits that are managed by the pharmacy benefit manager, or a consumer; and

(g) When subjecting a rural independent pharmacy to a recoupment of funds of more than one thousand dollars or a penalty of more than one thousand dollars as the result of an audit:

(I) Electronically notify the rural independent pharmacy of the rural independent pharmacy's rights to appeal pursuant to subsection (1)(e) of this section at least thirty days before the recoupment of funds;

(II) If the rural independent pharmacy does not respond to the electronic notification provided pursuant to subsection (1)(g)(I) of this section within thirty days after the electronic notification, again electronically notify the rural independent pharmacy of the rural independent pharmacy's rights to appeal pursuant to subsection (1)(e) of this section at least thirty days before the recoupment of funds; and

(III) If the rural independent pharmacy does not respond to the second electronic notification provided pursuant to subsection (1)(g)(II) of this section within thirty days after the second electronic notification, serve process on the rural independent pharmacy notifying of the rural independent pharmacy's rights to appeal pursuant to subsection (1)(e) of this section at least thirty days before the recoupment of funds.

(2) A pharmacy may use verifiable statements or records, including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner, to validate the pharmacy record and delivery.

(3) Any legal prescription may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, electronic prescriptions, or documented telephone calls from the prescriber or the prescriber's agent.

(4) The time period covered by an audit may not exceed twenty-four months from the date that the prescription was submitted to or adjudicated by the entity, unless a longer period is required by state or federal law.

(5) The time periods specified are waived for audits of pharmacy records when fraud or other intentional or willful misrepresentation is indicated through review of claims data, statements, physical review, or other investigative methods. The pharmacy benefit manager, carrier, or entity acting on behalf of the pharmacy benefit manager or carrier shall deliver to the pharmacy at the time of the audit a written or verbal explanation of the information that led to the conclusion that there is an indication of fraud or other intentional or willful misrepresentation. The explanation is not required if law enforcement has intervened due to the indication of fraud.

(5.5) Except under circumstances specified in subsection (5) of this section, on or after July 6, 2021, a pharmacy benefit manager, a carrier, or an entity acting on behalf of a PBM or a carrier shall not conduct an on-site audit of a pharmacy for which the PBM, carrier, or entity

acting on behalf of a PBM or a carrier has conducted an on-site audit within the immediately preceding twelve months.

(5.7) With regard to the requirements of this section applicable to pharmacy benefit managers, the commissioner has the authority to enforce this section and to impose a penalty or other remedy against a pharmacy benefit manager that fails to comply with this section.

(5.9) The commissioner may adopt rules to implement and enforce this section.

(6) As used in this section, "pharmacy" includes any entity authorized under article 280 of title 12 to dispense prescription drugs.

Source: L. 2013: Entire section added, (HB 13-1221), ch. 118, p. 403, § 1, effective August 7. **L. 2019:** (6) amended, (HB 19-1172), ch. 136, p. 1655, § 47, effective October 1. **L. 2021:** (5.5) added, (HB 21-1297), ch. 452, p. 2993, § 4, effective July 6. **L. 2023:** (5.7) and (5.9) added, (HB 23-1227), ch. 160, p. 696, § 4, effective August 7. **L. 2025:** (1)(e) and (1)(f) amended and (1)(g) added, (HB 25-1222), ch. 259, p. 1329, § 5, effective August 6.

Editor's note: Section 8(2) of chapter 259 (HB 25-1222), Session Laws of Colorado 2025, provides that the act changing this section applies to conduct occurring on or after August 6, 2025.

Cross references: For the legislative declaration in HB 21-1297, see section 1 of chapter 452, Session Laws of Colorado 2021. For the legislative declaration in HB 25-1222, see section 1 of chapter 259, Session Laws of Colorado 2025.

10-16-122.6. Pharmacy benefit managers - contracts with pharmacies - maximum allowable cost pricing - enforcement - rules. (1) (a) In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit manager, within ten days after any request, a current list of the sources used to determine maximum allowable cost pricing. The pharmacy benefit manager shall update the pricing information at least every seven days and provide a means by which contracted pharmacies may promptly review pricing updates in a format that is readily available and accessible.

(b) A pharmacy benefit manager shall maintain a procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner in order to remain consistent with pricing changes in the marketplace.

(2) In order to place a prescription drug on a maximum allowable cost list, a pharmacy benefit manager shall ensure that:

(a) The drug is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the orange book, or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and

(b) The drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete.

(3) Each contract between a pharmacy benefit manager and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes:

(a) A twenty-one-day limit on the right to appeal following the initial claim;

(b) A requirement that the appeal be investigated and resolved within twenty-one days after the appeal;

(c) A telephone number at which the pharmacy may contact the pharmacy benefit manager to speak to a person responsible for processing appeals;

(d) A requirement that a pharmacy benefit manager provide a reason for any appeal denial and the identification of the national drug code, as defined in section 10-16-122.9 (2)(f), of a drug that may be purchased by the pharmacy at a price at or below the benchmark price as determined by the pharmacy benefit manager; and

(e) A requirement that a pharmacy benefit manager make an adjustment to a date no later than one day after the date of determination. This requirement does not prohibit a pharmacy benefit manager from retroactively adjusting a claim for the appealing pharmacy or for another similarly situated pharmacy.

(4) The commissioner has the authority to enforce this section and to impose a penalty or other remedy against a pharmacy benefit manager that fails to comply with this section.

(5) The commissioner may adopt rules to implement and enforce this section.

Source: L. 2023: Entire section added with relocations, (HB 23-1227), ch. 160, p. 697, § 7, effective August 7.

Editor's note: This section is similar to former § 25-37-103.5 as it existed prior to 2023.

10-16-122.7. Disclosures between pharmacists and patients - carrier and PBM prohibitions - enforcement - short title - legislative declaration - preemption by federal law - rules. (1) The short title of this section is the "Patient Drug Costs Savings Act".

(2) The general assembly hereby finds and declares that:

(a) Consumers have the right to know about options to reduce the amount of money they pay at a pharmacy for prescription drugs; and

(b) This section will save consumers money by allowing pharmacists to provide information concerning the cost of prescription drugs.

(3) A carrier that has a contract with a pharmacy or pharmacist, or a pharmacy benefit management firm acting on behalf of a carrier, shall not:

(a) Prohibit a pharmacy or pharmacist from providing a covered person information on the amount of the covered person's cost share for the covered person's prescription drug and the clinical efficacy of a more affordable alternative drug that is therapeutically equivalent, as defined in section 12-280-103 (52), to the prescribed drug if one is available;

(b) Penalize a pharmacy or a pharmacist for disclosing the information described in subsection (3)(a) of this section to a covered person or selling a more affordable alternative to a covered person; or

(c) Require a pharmacy to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy.

(4) (a) If the commissioner determines that a carrier has not complied with this section, the commissioner shall institute a corrective action plan for the carrier to follow or use any of the commissioner's enforcement powers under this title 10 to obtain the carrier's compliance with this section.

(b) With regard to the requirements of this section applicable to PBMs, the commissioner has the authority to enforce this section and to impose a penalty or other remedy against a pharmacy benefit management firm that fails to comply with this section.

(5) If any provision of this section is inconsistent with, or in conflict with, an applicable federal law, rule, or regulation, the applicable federal law, rule, or regulation applies.

(6) The commissioner may adopt rules to implement and enforce this section.

Source: L. 2018: Entire section added, (HB 18-1284), ch. 181, p. 1233, § 1, effective August 8. **L. 2019:** (3)(a) amended, (HB 19-1172), ch. 136, p. 1655, § 48, effective October 1. **L. 2023:** (4) amended and (6) added, (HB 23-1227), ch. 160, p. 696, § 5, effective August 7.

10-16-122.8. Pharmacy benefit manager practices - agreements - fees - documentation - rules. [*Editor's note: This section is effective January 1, 2027.*]

(1) A pharmacy benefit manager may earn income derived from the assessment of a single, flat-dollar service fee for the provision of a prescription drug, which service fee is transparently expressed in a written agreement between the PBM and health benefit plan. The single, flat-dollar service fee may vary from client to client of the PBM based on the number of health benefit plan participants, clinical and administrative services provided, value-based payment arrangement, and other considerations.

(2) (a) Throughout the course of providing prescription drug benefits and claims processing services for health benefit plans, a PBM shall not:

(I) Earn any income that is directly or indirectly based on the price or cost of a prescription drug, including income from prescription drug mark-ups, copayments that exceed the cost of prescription drugs, up-charging or spread-pricing, or manufacturer-derived revenues; or

(II) Design a prescription drug formulary to favor a certain branded pharmaceutical or biologic over a therapeutically equivalent generic or biosimilar, unless the branded pharmaceutical or biologic has a lower net acquisition cost and that lower cost is reflected in a lower out-of-pocket expense for consumers.

(b) A PBM must be reimbursed by a health benefit plan for lowering aggregated prescription drug spending for the plan over a given period of time. A PBM must also be reimbursed for the direct services the PBM provides to the health benefit plan.

(c) A PBM may include in its contracts or other agreements with prescription drug manufacturers provisions that limit the increase of the wholesale acquisition cost of prescription drugs that they include in their formularies and benefit designs.

(d) This subsection (2) does not prevent a PBM from negotiating a prescription drug rebate or other discount as a percentage of the prescription drug's list price.

(3) Throughout the course of providing prescription drug benefits and claims processing services for health benefit plans, a PBM shall reimburse an unaffiliated pharmacy or a PBM-affiliated retail, mail order, or specialty pharmacy for the fulfillment of a prescription drug in an amount equal to the national average drug acquisition cost for the dispensed prescription drug ingredients and a reasonable and adequate dispensing fee. If the national average drug acquisition cost is not available at the time a prescription drug is administered or dispensed, a PBM shall not reimburse in an amount that is less than the wholesale acquisition cost of the prescription drug.

(4) (a) A contract between a PBM and a covered person's health benefit plan must include a provision that requires the PBM to disclose prescription drug cost information to the health benefit plan, including claims-level pharmacy data and PBM income derived from prohibited sources that the PBM must pass through to the health benefit plan. The information must be provided within thirty days after the date of the notification to the PBM by the health benefit plan or at regular negotiated reporting intervals necessary for the health benefit plan to determine the PBM's compliance with the contract terms and this section. The PBM shall assess no additional fees with regard to provision of this information.

(b) The contract between the PBM and a covered person's health benefit plan must include a provision authorizing the covered person's health benefit plan to annually execute an audit for the purpose of validating compliance with contract terms and this section.

(5) The commissioner may adopt rules as necessary to enforce this section.

Source: L. 2025: Entire section added, (HB 25-1094), ch. 303, p. 1583, § 1, effective January 1, 2027.

Editor's note: Section 2(2) of chapter 303 (HB 25-1094), Session Laws of Colorado 2025, provides that the act adding this section applies to conduct occurring on or after January 1, 2027.

10-16-122.9. Prescription drug benefits - real-time access to benefit information - enforcement - definitions - rules. (1) (a) Upon request of a covered person, the covered person's provider, or a third party on behalf of the covered person or provider, a carrier or, if a carrier uses a pharmacy benefit manager for claims processing services or other prescription drug or device services under a health benefit plan offered by the carrier, the PBM shall furnish the cost, benefit, and coverage data set forth in subsection (1)(c) of this section to the covered person, the covered person's provider, or the third party acting on behalf of the covered person or provider and shall ensure that the data is:

(I) Current and updated no later than one business day after any change is made;

(II) Provided in real time; and

(III) Provided in the same format that the request is made by the covered person, provider, or third party that made the request.

(b) (I) A covered person, the covered person's provider, or a third party acting on behalf of the covered person or provider shall submit the request for cost, benefit, and coverage data and the carrier or PBM shall respond to the request using established industry content and transport standards published by:

(A) A standards-developing organization accredited by the American National Standards Institute or its successor entity, including the National Council for Prescription Drug Programs, the Accredited Standards Committee, or Health Level Seven International, or their successor entities; or

(B) A relevant federal or state governing body, including the CMS or the office of the national coordinator for health information technology in the federal department of health and human services.

(II) A facsimile, proprietary payer or patient portal, or other electronic form is not an acceptable electronic format pursuant to this section.

(c) (I) Upon receipt of a request for cost, benefit, and coverage data pursuant to this subsection (1), the carrier or PBM, as applicable, shall provide the following data for any drug covered under the covered person's health benefit plan:

(A) The covered person's eligibility information for the drug;

(B) A list of any clinically appropriate alternatives to the drug that are covered under the covered person's health benefit plan;

(C) Cost-sharing information for the drug and for clinically appropriate alternatives, including a description of any variance in cost-sharing based on a pharmacy, whether retail or mail order, or provider dispensing or administering the drug or alternatives; and

(D) Any applicable utilization management requirements for the drug or clinically appropriate alternatives, including prior authorization, step therapy, quantity limits, and site-of-service restrictions.

(II) The carrier or PBM shall furnish the data specified in subsection (1)(c)(I) of this section, whether the request is made using the drug's unique billing code, such as a national drug code or Healthcare Common Procedure Coding System code, or a descriptive term, such as the brand or generic name of the drug. A carrier or PBM shall not deny or delay a request for cost, benefit, and coverage data as a method of blocking the data from being shared based on how the drug was requested.

(d) A carrier or PBM furnishing the data requested pursuant to this subsection (1) shall not:

(I) Restrict, prohibit, or otherwise hinder a provider from communicating or sharing with the covered person:

(A) Any of the data set forth in subsection (1)(c)(I) of this section;

(B) Additional information on any lower-cost or clinically appropriate alternatives, whether or not the alternatives are covered under the covered person's plan; or

(C) Additional payment or cost-sharing information that may reduce the covered person's out-of-pocket costs, such as cash price or patient assistance and support programs, whether sponsored by a manufacturer, foundation, or other entity;

(II) Except as may be required by law, interfere with, prevent, or materially discourage access, exchange, or use of the data set forth in subsection (1)(c)(I) of this section, which may include:

(A) Charging fees;

(B) Failing to respond to a request, at the time the request is made, when a response is reasonably possible;

(C) Implementing technology in nonstandard ways or instituting covered person consent requirements, processes, policies, procedures, or renewals that are likely to substantially increase the complexity or burden of accessing, exchanging, or using the data; or

(III) Penalize a provider for disclosing the information to a covered person or prescribing, administering, or ordering a clinically appropriate or lower-cost alternative.

(e) A carrier or PBM shall treat a personal representative of a covered person as the covered person for purposes of this section. If, under applicable law, a person has authority to act on behalf of a covered person in making decisions related to health care, a carrier or PBM, or affiliates or entities acting on behalf of the carrier or PBM, must treat the person as a personal representative of the covered person for purposes of this section.

(1.5) With regard to the requirements of this section applicable to PBMs, the commissioner has the authority to enforce this section and to impose a penalty or other remedy against a PBM that fails to comply with this section.

(1.7) The commissioner may adopt rules to implement and enforce this section.

(2) As used in this section, unless the context otherwise requires:

(a) "CMS" means the federal centers for medicare and medicaid services in the United States department of health and human services.

(b) "Cost-sharing information" means the amount a covered person is required to pay for a drug that is covered under the covered person's health benefit plan.

(c) "Covered" or "coverage" means those health-care services to which a covered person is entitled under the terms of the covered person's health benefit plan.

(d) "Drug" means any prescription drug or medication covered under a health benefit plan, whether ordered, prescribed, or administered.

(e) "Healthcare Common Procedure Coding System" means the system developed by the CMS for identifying health-care services in a consistent and standardized manner.

(f) "National drug code" means the unique, three-segment identifier number used by the FDA to identify drugs that are manufactured, prepared, propagated, compounded, or processed for sale in the United States.

(g) "Third party" means a person, other than a PBM, that is not an enrollee in or a covered person under a health benefit plan.

Source: L. 2021: Entire section added, (HB 21-1297), ch. 452, p. 2994, § 5, effective July 6. **L. 2023:** (1.5) and (1.7) added, (HB 23-1227), ch. 160, p. 696, § 6, effective August 7.

Cross references: (1) For additional definitions applicable to this section, see § 10-16-122.1.

(2) For the legislative declaration in HB 21-1297, see section 1 of chapter 452, Session Laws of Colorado 2021.

10-16-123. Telehealth - definitions. (1) It is the intent of the general assembly to recognize the practice of telehealth as a legitimate means by which an individual may receive health-care services from a provider without in-person contact with the provider.

(2) (a) A health benefit plan or dental plan that is issued, amended, or renewed in this state shall not require in-person contact between a provider and a covered person for services appropriately provided through telehealth, subject to all terms and conditions of the health benefit plan or dental plan. Nothing in this section requires the use of telehealth when a provider determines that delivery of care through telehealth is not appropriate or when a covered person chooses not to receive care through telehealth. A provider is not obligated to document or demonstrate that a barrier to in-person care exists to trigger coverage under a health benefit plan or dental plan for services provided through telehealth.

(b) (I) Subject to all terms and conditions of the health benefit plan or dental plan, a carrier shall reimburse the treating participating provider or the consulting participating provider for the diagnosis, consultation, or treatment of the covered person delivered through telehealth on the same basis that the carrier is responsible for reimbursing that provider for the provision of the same service through in-person consultation or contact by that provider.

(II) A carrier shall not restrict or deny coverage of a health-care service that is a covered benefit solely:

(A) Because the service is provided through telehealth rather than in-person consultation or contact between the participating provider or, subject to section 10-16-704, the nonparticipating provider and the covered person where the health-care service is appropriately provided through telehealth; or

(B) Based on the communication technology or application used to deliver the telehealth services pursuant to this section.

(III) Section 10-16-704 applies to this subsection (2)(b), and the availability of telehealth services does not modify the requirements imposed on carriers under that section to provide a sufficient network of providers available in the community to provide in-person health-care services.

(c) A carrier shall include in the payment for telehealth interactions reasonable compensation to the originating site for the transmission cost incurred during the delivery of health-care services through telehealth; except that, for purposes of this subsection (2)(c), the carrier is not required to pay or reimburse for any transmission costs the covered person incurred or originating site fees, regardless of how or by whom the fees are billed, for the delivery of health-care services through telehealth to or from the covered person's home or a private residence.

(d) A carrier may offer a health coverage plan or dental plan containing a deductible, copayment, or coinsurance requirement for a health-care service provided through telehealth, but the deductible, copayment, or coinsurance amount must not exceed the deductible, copayment, or coinsurance applicable if the same health-care services are provided through in-person diagnosis, consultation, or treatment.

(e) A carrier shall not:

(I) Impose an annual dollar maximum on coverage for health-care services covered under the health benefit plan or dental plan that are delivered through telehealth, other than an annual dollar maximum that applies to the same services when performed by the same provider through in-person care;

(II) Impose specific requirements or limitations on the HIPAA-compliant technologies that a provider uses to deliver telehealth services, including limitations on audio or live video technologies;

(III) Require a covered person to have a previously established patient-provider relationship with a specific provider in order for the covered person to receive medically necessary telehealth services from the provider; or

(IV) Impose additional certification, location, or training requirements on a provider as a condition of reimbursing the provider for providing health-care services through telehealth.

(f) If a covered person receives health-care services through telehealth, a carrier shall apply the applicable copayment, coinsurance, or deductible amount to the telehealth services under the health benefit plan or dental plan, which copayment, coinsurance, or deductible amount shall not exceed the amounts applicable to those health-care services when performed by the same provider through in-person care.

(g) (I) Repealed.

(II) This section does not apply to:

(A) Short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts; or

(B) Policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the "Social Security Act", as amended, or any other similar coverage under state or federal governmental plans.

(h) Nothing in this section prohibits a carrier from providing coverage or reimbursement for health-care services appropriately provided through telehealth to a covered person who is not located at an originating site.

(3) A health benefit plan or dental plan is not required to pay for consultation provided by a provider by telephone or facsimile unless the consultation is provided through HIPAA-compliant interactive audio-visual communication or the use of a HIPAA-compliant application via a cellular telephone.

(4) As used in this section:

(a) "Distant site" means a site at which a provider is located while providing health-care services by means of telehealth.

(b) "Originating site" means a site at which a patient is located at the time health-care services are provided to him or her by means of telehealth.

(b.5) "Remote monitoring" means the use of synchronous or asynchronous technologies to collect or monitor medical and other forms of health data for individuals at an originating site and electronically transmit that information to providers at a distant site so providers can assess, diagnose, consult, treat, educate, provide care management, suggest self-management, or make recommendations regarding a covered person's health care.

(c) "Store-and-forward transfer" means the electronic transfer of a patient's medical information or an interaction between providers that occurs between an originating site and distant sites when the patient is not present.

(d) Repealed.

(e) "Telehealth" means a mode of delivery of health-care services through HIPAA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site.

Source: L. 2001: Entire section added, p. 1153, § 3, effective January 1, 2002. **L. 2015:** (1) and (2) amended and (4) added, (HB 15-1029), ch. 38, p. 93, § 1, effective January 1, 2017. **L. 2017:** (2)(b), (2)(c), (2)(f), (3), and (4)(e) amended, (HB 17-1094), ch. 36, p. 108, § 1, effective March 16. **L. 2020:** (2)(e) and (4)(e) amended, (4)(b.5) added, and (4)(d) repealed, (SB 20-212), ch. 235, p. 1139, § 2, effective July 6. **L. 2021:** (2)(a), (2)(b)(I), (2)(d), (2)(e)(I), (2)(f), and (3) amended and (2)(g)(I) repealed, (SB 21-139), ch. 113, p. 442, § 1, effective May 7.

Cross references: For the legislative declaration contained in the 2001 act enacting this section, see section 1 of chapter 300, Session Laws of Colorado 2001. For the legislative declaration in SB 20-212, see section 1 of chapter 235, Session Laws of Colorado 2020.

10-16-124. Prescription information cards - legislative declaration. (1) It is the intent of the general assembly to lessen patients' waiting times for prescriptions, to decrease administrative burdens for pharmacies, and to improve care to patients by minimizing confusion, eliminating unnecessary paperwork, and streamlining the dispensing of prescription drugs paid for by third party payors.

(2) Each health benefit plan that offers coverage for prescription drugs shall issue to the named insured a card or other device containing uniform prescription drug information. Such card or device shall be in the format approved by the national council for prescription drug programs, shall include all of the required and situational fields and shall conform to the most recent pharmacy identification card or device implementation guide produced by the national council for prescription drug programs.

(3) (a) A new uniform prescription drug information card or device, as required pursuant to subsection (2) of this section, shall be issued by a carrier:

(I) When a person enrolls in a health benefit plan that offers prescription drug coverage; and

(II) When a person's coverage changes and the change affects data contained on the card or device.

(b) Newly issued cards or devices shall be updated with the latest coverage information and shall conform to the national council for prescription drug programs' standards then in effect and to the implementation guide then in use.

(4) No health maintenance organization that supplies benefits to its plan subscribers through an in-house drug or pharmacy outlet and has received a certificate of authority pursuant to part 4 of this article shall be subject to this section.

(5) The provisions of the section shall not apply to the children's basic health plan as described in article 8 of title 25.5, C.R.S.

Source: L. 2002: Entire section added, p. 1311, § 1, effective January 1, 2003. **L. 2006:** (5) amended, p. 1999, § 36, effective July 1.

10-16-124.5. Prior authorization form - drug benefits - program - chronic maintenance drugs - rules of commissioner - definitions - repeal. (1) (a) Notwithstanding any other provision of law but subject to paragraph (b) of this subsection (1), on and after January 1, 2015, a carrier or, if a carrier contracts with a pharmacy benefit management firm to perform prior authorization services for drug benefits, the pharmacy benefit management firm, shall utilize the prior authorization process developed pursuant to subsection (3) of this section when requiring prior authorization for drug benefits.

(b) This section does not apply to a nonprofit health maintenance organization with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group.

(2) (a) Except as provided in subsection (2)(b) or (2)(c) of this section, a prior authorization request is deemed granted if a carrier or pharmacy benefit management firm fails to:

(I) Utilize the prior authorization process developed pursuant to subsection (3) of this section;

(II) For prior authorization requests submitted electronically:

(A) **[*Editor's note: For the applicability of this subsection (2)(a)(II)(A) on or after January 1, 2026, see the editor's note following this section.*]** Notify the prescribing provider, within two business days after receipt of the request, that the request is approved, denied, or incomplete and, if incomplete, indicate the specific additional information, consistent with criteria posted pursuant to subsection (3.5)(a) of this section, that is required to process the request; or

(B) Notify the prescribing provider, within two business days after receiving the additional information required by the carrier or pharmacy benefit management firm pursuant to sub-subparagraph (A) of this subparagraph (II), that the request is approved or denied;

(III) For nonurgent prior authorization requests submitted orally or by facsimile or electronic mail, notify the prescribing provider, within three business days after receipt of the request, that the request is approved or denied; and

(IV) For urgent prior authorization requests submitted orally or by facsimile or electronic mail, notify the prescribing provider, within one day after receipt of the request, that the request is approved or denied.

(b) If a carrier or pharmacy benefit management firm notifies the prescribing provider pursuant to sub-subparagraph (A) of subparagraph (II) of paragraph (a) of this subsection (2) that a prior authorization request is incomplete and that additional information is required, the prescribing provider shall submit the additional information within two business days after receipt of the notice from the carrier or pharmacy benefit management firm. If the prescribing provider fails to submit the required additional information within two business days after receipt of the notice, the request is not deemed granted pursuant to paragraph (a) of this subsection (2). After receipt of the required additional information, the carrier or pharmacy benefit management firm shall respond to the prior authorization request in accordance with sub-subparagraph (B) of subparagraph (II) of paragraph (a) of this subsection (2).

(c) For nonurgent prior authorization requests related to a covered person's HIV prescription drug coverage, the prior authorization request is deemed granted if a carrier or pharmacy benefit management firm fails to:

(I) Utilize the prior authorization process developed pursuant to subsection (3) of this section;

(II) For prior authorization requests submitted electronically:

(A) **[*Editor's note: For the applicability of this subsection (2)(c)(II)(A) on or after January 1, 2026, see the editor's note following this section.*]** Notify the prescribing provider, within one business day after receipt of the request, that the request is approved, denied, or incomplete and, if incomplete, indicate the specific additional information, consistent with criteria posted pursuant to subsection (3.5)(a) of this section, that is required to process the request; or

(B) Notify the prescribing provider within one business day after receiving the additional information required by the carrier or pharmacy benefit management firm pursuant to subsection (2)(a)(II)(A) of this section that the request is approved or denied; and

(III) For nonurgent and urgent prior authorization requests submitted orally, by facsimile, or by electronic mail, notify the prescribing provider within one day after receipt of the request that the request is approved or denied.

(c.5) This subsection (2)(c.5) and subsection (2)(c) of this section are repealed, effective July 1, 2027.

(3) (a) **[*Editor's note: For the applicability of this introductory portion to subsection (3)(a) on or after January 1, 2026, see the editor's note following this section.*]** The commissioner shall develop, by rule, a uniform prior authorization process that:

(I) **[*Editor's note: For the applicability of this subsection (3)(a)(I) on or after January 1, 2026, see the editor's note following this section.*]** Is made available electronically by the carrier or pharmacy benefit management firm, does not require the prescribing provider to submit a prior authorization request electronically, and satisfies the requirements of subsection (3.3) of this section;

(II) Repealed.

(III) Ensures that carriers and pharmacy benefit management firms use evidence-based guidelines, when possible, when making prior authorization determinations;

(IV) Permits, but does not require, a prescribing provider to submit a request for a prior authorization for drug benefits electronically to the carrier or pharmacy benefit management firm;

(V) Requires carriers and pharmacy benefit management firms, when notifying the prescribing provider of its decision to approve a prior authorization request, to include in the notice a unique prior authorization number attributable to the particular request, specification of the particular drug benefit approved, the next date for review of the approved drug benefit, and a link to the current criteria that the prescribing provider will need to submit for reapproval of the prior authorization; and

(VI) **[*Editor's note: For the applicability of this subsection (3)(a)(VI) on or after January 1, 2026, see the editor's note following this section.*]** Requires carriers and pharmacy benefit management firms, when notifying a prescribing provider of its decision to deny a prior authorization request, to include the information required by section 10-16-112.5 (3)(c)(II) and a notice that the covered person has a right to appeal the adverse determination pursuant to sections 10-16-113 and 10-16-113.5.

(b) **[*Editor's note: For the applicability of this introductory portion to subsection (3)(b) on or after January 1, 2026, see the editor's note following this section.*]** In developing the uniform prior authorization process, the commissioner shall take into consideration the following:

(I) National standards pertaining to electronic prior authorization, including, but not limited to, standards referenced in federal law;

(II) Whether the prior authorization process should require carriers and pharmacy benefit management firms, when reviewing a prior authorization request, to use clearly accessible, consistently applied, and written clinical criteria based on medical necessity or the appropriateness of the drug benefit for the covered person;

(III) Whether the prior authorization process should require carriers to take into account, in determining criteria for prior authorizations, the Colorado part B medicare contractor local coverage determinations, the federal centers for medicare and medicaid services national coverage determinations, and specialty society guidelines, such as those of the American Society of Clinical Oncology; and

(IV) Whether carriers and pharmacy benefit management firms could use a rules engine with criteria-driven questions that lead to an immediate determination of a prior authorization request or request for submittal of specific additional information needed to make the determination.

(c) In addition to the prior authorization process, the commissioner shall develop, by rule, a standardized prior authorization form, not to exceed two pages in length, for use in submitting electronic and nonelectronic prior authorization requests. In developing the form, the commissioner shall take into consideration existing forms, including existing prior authorization forms established by the federal centers for medicare and medicaid services or the department of health care policy and financing.

(3.3) **[*Editor's note: For the applicability of this subsection (3.3) on or after January 1, 2026, see the editor's note following this section.*]** Starting January 1, 2027, if a provider submits a prior authorization request to a carrier or PBM through a secure electronic transmission system the carrier or PBM uses that complies with the most recent version of the National Council for Prescription Drug Programs SCRIPT standard, or its successor standard, and 21 CFR 1311, the carrier or PBM shall accept and respond to the request through the secure electronic transmission system.

(3.5) **[*Editor's note: For the applicability of this subsection (3.5) on or after January 1, 2026, see the editor's note following this section.*]**

(a) On and after January 1, 2026, a carrier shall post on the carrier's public-facing website, in a readily accessible, standardized, searchable format, prior authorization requirements as applicable to the prescription drug formulary for each health benefit plan the carrier offers, including the following information:

(I) The carrier's prior authorization requirements and restrictions, including a list of drugs that require prior authorization;

(II) Written clinical criteria that are easily understandable to the prescribing provider and that include the clinical criteria for reauthorization of a previously approved drug after the prior authorization period has expired;

(III) The standard form for submitting prior authorization requests;

(IV) The health benefit plan to which the formulary applies;

(V) Each prescription drug that is covered under the health benefit plan, including both generic and brand-name versions of a prescription drug;

(VI) Any prescription drugs on the formulary that are preferred over other prescription drugs or any alternative prescription drugs that do not require prior authorization;

(VII) Any exclusions from or restrictions on coverage, including:

(A) Any tiering structure, including copayment and coinsurance requirements;

(B) Prior authorization, step therapy, and other utilization management controls;

(C) Quantity limits; and

(D) Whether access is dependent upon the location where a prescription drug is obtained or administered; and

(VIII) The appeal process for a denial of coverage or adverse determination for an item or service for a prescription drug.

(b) The commissioner shall adopt rules as necessary to implement this subsection (3.5).

(4) Repealed.

(5) **[*Editor's note: For the applicability of this subsection (5) on or after January 1, 2026, see the editor's note following this section.*]**

(a) Notwithstanding any other provision of law, and except as provided in subsections (5)(b) and (5.5) of this section, every prescribing provider shall use the prior authorization process developed pursuant to subsection (3) of this section to request prior authorization for coverage of

drug benefits, and every carrier and pharmacy benefit management firm shall use that process for prior authorization for drug benefits.

(b) (I) A carrier or PBM that provides drug benefits under a health benefit plan shall not impose prior authorization requirements under the health benefit plan more than once every three years for a drug that is approved by the FDA and that is a chronic maintenance drug if the carrier or PBM has previously approved a prior authorization for the covered person for use of the chronic maintenance drug.

(II) This subsection (5)(b) does not apply if:

(A) There is evidence that the authorization was obtained from the carrier or PBM based on fraud or misrepresentation;

(B) Final action by the FDA or other regulatory agencies, or the manufacturer, removes the chronic maintenance drug from the market, limits its use in a manner that affects the authorization, or communicates a patient safety issue that would affect the authorization alone or in combination with other authorizations;

(C) A generic equivalent or drug that is biosimilar, as defined in 42 U.S.C. sec. 262 (i)(2), to the prescribed chronic maintenance drug is added to the carrier's or PBM's drug formulary; or

(D) The wholesale acquisition cost of the chronic maintenance drug exceeds a dollar amount as established by the commissioner by rule, which amount must be no less than thirty thousand dollars for a twelve-month supply or for a course of treatment that is less than twelve months in duration.

(III) Nothing in this subsection (5)(b) requires a carrier or PBM to pay for a benefit:

(A) That is not a covered benefit under the health benefit plan; or

(B) If the patient is no longer a covered person under the health benefit plan on the date the chronic maintenance drug was prescribed, dispensed, administered, or delivered.

(IV) As used in this subsection (5)(b), "chronic maintenance drug" has the meaning set forth in section 12-280-103 (9.5).

(5.5) **[*Editor's note: For the applicability of this subsection (5.5) on or after January 1, 2026, see the editor's note following this section.*]**

(a) No later than January 1, 2026, a carrier or PBM shall adopt a program, developed in consultation with providers participating with the carrier, to eliminate or substantially modify prior authorization requirements in a manner that removes the administrative burden for qualified providers, as defined under the program, and their patients for certain prescription drugs and related drug benefits based on any of the following:

(I) The performance of providers with respect to adherence to nationally recognized, evidence-based medical guidelines, appropriateness, efficiency, and other quality criteria; and

(II) Provider specialty, experience, or other objective factors; except that eligibility for the program must not be limited by provider specialty.

(b) A program developed pursuant to subsection (5.5)(a) of this section:

(I) Must not require qualified providers to request participation in the program; and

(II) May include limiting the use of prior authorization to providers whose prescribing or ordering patterns differ significantly from the patterns of their peers after adjusting for patient mix and other relevant factors and in order to present those providers with opportunities for improvement in adherence to the carrier's or organization's prior authorization requirements.

(c) At least annually, a carrier or PBM shall:

(I) Reexamine a provider's prescribing or ordering patterns;

(II) Reevaluate the provider's status for exemption from prior authorization requirements or for inclusion in the program developed pursuant to subsection (5.5)(a) of this section; and

(III) Notify the provider of the provider's status for exemption or inclusion in the program.

(d) A program developed pursuant to subsection (5.5)(a) of this section must include procedures for a provider to request:

(I) An expedited, informal resolution of a carrier's or PBM's failure or refusal to include the provider in the program; and

(II) If the matter is not resolved through informal resolution, binding arbitration as specified in subsection (5.5)(e) of this section.

(e) If a provider requests binding arbitration pursuant to the procedures a carrier or a PBM develops under subsection (5.5)(d)(II) of this section, the following provisions govern the arbitration procedure:

(I) The provider and carrier or PBM shall jointly select an arbitrator from the list of arbitrators approved pursuant to section 10-16-704 (15)(b). Neither the provider nor the carrier or PBM is required to notify the division of the arbitration or of the selected arbitrator.

(II) The selected arbitrator shall determine the provider's eligibility to participate in the carrier's or PBM's program based on the program criteria developed pursuant to subsection (5.5)(a) of this section;

(III) Within thirty days after the date the arbitrator accepts the matter, the provider and the carrier or PBM shall submit to the arbitrator written materials in support of their respective positions;

(IV) The arbitrator may render a decision based on the written materials submitted pursuant to subsection (5.5)(e)(III) of this section or may schedule a hearing, lasting not longer than one day, for the provider and carrier or PBM to present evidence;

(V) Within thirty days after the date the arbitrator receives the written materials or, if a hearing is conducted, the date of the hearing, the arbitrator shall issue a written decision stating whether the provider is eligible for the program; and

(VI) If the arbitrator overturns the carrier's or PBM's failure or refusal to include the provider in the program, the carrier or PBM shall pay the arbitrator's fees and costs, and if the arbitrator affirms the carrier's or PBM's failure or refusal to include the provider in the program, the provider shall pay the arbitrator's fees and costs.

(6) **[*Editor's note: For the applicability of this subsection (6) on or after January 1, 2026, see the editor's note following this section.*]** Upon approval by the carrier or pharmacy benefit management firm, a prior authorization is valid for at least one calendar year after the date of approval. If, as a result of a change to the carrier's formulary, the drug for which the carrier or pharmacy benefit management firm has provided prior authorization is removed from the formulary or moved to a less preferred tier status, the change in the status of the previously approved drug does not affect a covered person who received prior authorization before the effective date of the change for the remainder of the covered person's plan year. Nothing in this subsection (6) limits the ability of a carrier or pharmacy benefit management firm, in accordance with the terms of the health benefit plan, to substitute a generic drug, with the prescribing provider's approval and patient's consent, for a previously approved brand-name drug.

(6.2) Consistent with available evidence-based guidelines, a prescribing provider may adjust the dose or frequency of a prescription drug to meet the specific medical needs of a covered person without prior authorization or subsequent utilization management, as defined in section 10-16-1002 (10), related to the dose or frequency adjustment if:

(a) The prescription drug is a chronic maintenance drug, as defined in section 12-280-103 (9.5), that has previously been approved for coverage by the carrier or PBM for the covered person's chronic or debilitating disease and the prescribing provider continues to prescribe the drug for the same chronic or debilitating disease;

(b) The prescription drug is not an opioid or a scheduled controlled substance; and

(c) The dose or frequency has not been adjusted more than two times without prior authorization.

(6.5) **[*Editor's note: For the applicability of this subsection (6.5) on or after January 1, 2026, see the editor's note following this section.*]** The commissioner may enforce the requirements of this section and impose a penalty or other remedy against a person that violates this section.

(7) For purposes of this section, a prior authorization request is submitted "electronically" if the prescribing provider submits the request to the carrier or pharmacy benefit management firm through a secure, web-based internet portal. A prior authorization request submitted by electronic mail is not submitted "electronically".

(8) As used in this section:

(a) "Prescribing provider" means a provider who is:

(I) Authorized by law to prescribe any drug or device to treat a medical condition of a covered person; and

(II) Acting within the scope of that authority.

(b) "Urgent prior authorization request" means a request for prior authorization of a drug benefit that, based on the reasonable opinion of the prescribing provider with knowledge of the covered person's medical condition, if determined in the time allowed for nonurgent prior authorization requests, could:

(I) Seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(II) Subject the covered person to severe pain that cannot be adequately managed without the drug benefit that is the subject of the prior authorization request.

Source: L. 2013: Entire section added, (SB 13-277), ch. 229, p. 1093, § 2, effective May 15. **L. 2018:** (8)(b) amended, (HB 18-1007), ch. 225, p. 1432, § 3, effective January 1, 2019. **L. 2019:** (8)(b) amended, (HB 19-1269), ch. 195, p. 2129, § 7, effective May 16. **L. 2023:** IP(2)(a) amended and (2)(c) and (2)(c.5) added, (SB 23-189), ch. 69, p. 262, § 12, effective April 14. **L. 2024:** (2)(a)(II)(A), (2)(c)(II)(A), IP(3)(a), (3)(a)(I), (3)(a)(VI), IP(3)(b), (5), and (6) amended, (3)(a)(II) and (4) repealed, and (3.3), (3.5), (5.5), and (6.5) added, (HB 24-1149), ch. 333, p. 2262, § 3, effective August 7. **L. 2025:** (6.2) added, (SB 25-301), ch. 288, p. 1484, § 1, effective August 6.

Editor's note: Section 5(2) of chapter 333 (HB 24-1149), Session Laws of Colorado 2024, provides that the act changing this section applies to conduct occurring on or after January 1, 2026.

Cross references: (1) For the legislative declaration in the 2013 act adding this section, see section 1 of chapter 229, Session Laws of Colorado 2013. For the legislative declaration in HB 24-1149, see section 1 of chapter 333, Session Laws of Colorado 2024.

(2) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

10-16-124.6. Drugs used for substance use disorder - prior authorization prohibited. A carrier that provides coverage under a health benefit plan for a drug used to treat a substance use disorder shall not require prior authorization, as defined in section 10-16-112.5 (7)(d), for the drug based solely on the dosage amount.

Source: L. 2024: Entire section added, (HB 24-1045), ch. 470, p. 3277, § 1, effective August 7.

10-16-124.7. Opioid analgesics with abuse-deterrent properties - study - definitions. (1) The governor shall direct the Colorado consortium for prescription drug abuse prevention to study the barriers to the use of abuse-deterrent opioid analgesic drug products as a way to reduce abuse and diversion of opioid drug products. On or before January 15, 2017, the consortium shall report its findings to the public health care and human services committee and the health, insurance, and environment committee of the house of representatives and the health and human services committee of the senate, or their successor committees.

(2) Moneys from the general fund shall not be used for the implementation of this section.

(3) As used in this section:

(a) "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the FDA with abuse-deterrence labeling claims that indicate that the drug product is expected to result in a meaningful reduction in abuse.

(b) "Opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release or long-acting form, that may be combined with other drug substances to form a single drug product or dosage form.

Source: L. 2015: Entire section added, (HB 15-1214), ch. 175, p. 570, § 1, effective May 11. **L. 2022:** (3)(a) amended, (HB 22-1264), ch. 126, p. 888, § 4, effective August 10.

10-16-124.8. Colorado consortium for prescription drug abuse prevention - create process for recovery - report. (1) The governor shall direct the Colorado consortium for prescription drug abuse prevention within the university of Colorado to:

(a) Create a process with the substance abuse recovery community to develop a strategic plan that addresses the full continuum of recovery services, including detoxification services and reintegration into the community with peer support, for individuals who experience substance use disorders;

(b) Develop a definition for recovery residences and issue recommendations regarding whether recovery residences should be licensed; and

(c) Report the recommendations pursuant to this section to the general assembly on or before January 1, 2020.

(2) Money in the general fund may not be used for the implementation of this section.

Source: L. 2018: Entire section added, (HB 18-1003), ch. 224, p. 1427, § 2, effective May 21.

10-16-125. Reimbursement to nurses. (1) In counties of the state that are neither part of a metropolitan statistical area nor a primary statistical area, a carrier offering a health benefit plan shall not discriminate between a physician and an advanced practice registered nurse not practicing under the direction of a physician when establishing reimbursement rates for covered services that could be provided by an advanced practice registered nurse or a physician.

(2) In order to improve access to primary care and choices of providers, a carrier providing a health benefit plan shall evaluate an application for status as a participating provider from an advanced practice registered nurse utilizing objective and reasonable criteria and shall take into account the provider-to-covered-person ratio for the covered benefits that appropriately may be provided by the advanced practice registered nurse. The carrier shall make a determination on an application for participating provider status submitted by an advanced practice registered nurse, and notify the applicant of its determination, within the same period in which the carrier makes a participating provider determination for physicians. If the application is denied, the carrier shall specify the reason for the denial. If the application is approved, the carrier shall list the advanced practice registered nurse in the provider directory for the health benefit plan.

Source: L. 2002: Entire section added, p. 1295, § 8, effective June 7. **L. 2008:** Entire section amended, p. 121, § 1, effective January 1, 2009.

Editor's note: This section was originally enacted as § 10-16-124 in House Bill 02-1003 but has been renumbered on revision for ease of location.

10-16-126. Fee-for-service dental plans. (1) Notwithstanding any provision of this title to the contrary, a fee-for-service dental plan for which premiums are not charged is not subject to the provisions of this title and the offering of such a plan shall not be considered transacting the business of insurance pursuant to section 10-3-903. The offeror of a fee-for-service dental plan shall have no liability for payment of claims and the fees paid to the provider of the services shall be paid directly by the consumer.

(2) Any offeror of such fee-for-service dental plan shall advise the consumer that the plan is not an insurance plan and that the consumer shall be solely responsible for full payment to the provider of any fees or charges incurred by the consumer.

Source: L. 2003: Entire section added, p. 1740, § 1, effective August 6.

10-16-127. Coinsurance and deductibles. A carrier subject to the provisions of parts 2, 3, and 4 of this article may offer one or more health coverage plans that contain deductibles or

coinsurance without any limitation or restriction on the maximum out-of-pocket payable by the insured.

Source: L. 2003: Entire section added, p. 1785, § 16, effective January 1, 2004.

Editor's note: This section was originally numbered as § 10-16-126 but was renumbered on revision for ease of location.

10-16-128. Annual report to general assembly. Notwithstanding section 24-1-136 (11)(a)(I), the commissioner shall report to the business affairs and labor committee of the house of representatives and the business, labor, and technology committee of the senate, or any successor committees, no later than October 1, 2004, and every October 1 thereafter. The report shall be an indication of the number, nature, and outcome of complaints against insurers during the preceding twelve months.

Source: L. 2003: Entire section added, p. 2494, § 3, effective June 5. **L. 2007:** Entire section amended, p. 2020, § 12, effective June 1. **L. 2017:** Entire section amended, (SB 17-044), ch. 4, p. 7, § 4, effective August 9.

Editor's note: This section was originally numbered as § 10-16-126 but was renumbered on revision for ease of location.

10-16-129. Health savings accounts. Any carrier authorized to conduct business in this state that offers coverage pursuant to part 2, 3, or 4 of this article may offer a high deductible health plan that would qualify for and may be offered in conjunction with a health savings account pursuant to 26 U.S.C. sec. 223, as amended. A carrier offering a high deductible health plan that may be offered in conjunction with a health savings account may apply the deductible to mandatory health benefits for prostate cancer screening and prosthetic devices pursuant to section 10-16-104 (10) and (14) if those mandatory benefits are not considered by the federal department of treasury to be preventive or to have an acceptable deductible amount.

Source: L. 2004: Entire section added, p. 764, § 2, effective July 1. **L. 2009:** Entire section amended, (HB 09-1204), ch. 344, p. 1808, § 6, effective January 1, 2010. **L. 2013:** Entire section amended, (HB 13-1266), ch. 217, p. 973, § 23, effective May 13.

Cross references: For the legislative declaration contained in the 2009 act amending this section, see section 1 of chapter 344, Session Laws of Colorado 2009.

10-16-130. Disclosure of rate increases to public entities - legislative declaration - definitions. (1) The general assembly hereby finds, determines, and declares that variability in premiums by carriers offering health benefit coverage to a public entity present difficulties for fiscal planning for the public entity. Therefore, it is in the best interest of the state to promote greater accountability to the public and sound fiscal policy by public entities through disclosure by health insurance carriers of information concerning the public entity's rate, loss ratio, and the total number of claims exceeding ten thousand dollars for the public entity.

(2) A carrier authorized to conduct business in this state that offers coverage pursuant to part 2, 3, or 4 of this article to a public entity, with one hundred or more employees enrolled in such coverage, shall disclose to the public entity, at the request of the public entity, once annually and concurrent with the issuance of the employer's rate renewal, the following information as it relates to the amounts of coverage being considered for calculating the renewal:

(a) The total number of employees covered by the carrier for the public entity;

(b) The total dollar amount of claims paid by the carrier on behalf of the public entity;

(c) Total of premiums paid; and

(d) The number of claims that exceed ten thousand dollars for any one covered person under health benefit coverage for the public entity.

(3) As used in this section, unless the context otherwise requires:

(a) "Loss ratio" means the total claims paid for the coverage period divided by the total amount of premiums paid by a public entity.

(b) "Public entity" shall have the same meaning as that provided in section 24-10-103 (5), C.R.S.

Source: L. 2005: Entire section added, p. 849, § 1, effective January 1, 2006.

10-16-131. Health care reform project - blue ribbon commission for health care reform - repeal. (Repealed)

Source: L. 2006: Entire section added, p. 1626, § 2, effective June 2. **L. 2007:** IP(3)(a) amended and (3)(a)(IV) and (3)(b)(III) added, p. 167, §§ 1, 2, effective March 22; (2), (3)(d)(V), (4)(a), (4)(b)(III), (4)(b)(IV), (5)(a), and (5)(c) amended and (4.5) and (5.5) added, p. 1993, § 1, effective June 1. **L. 2008:** (5.3) added and (6) amended, p. 809, § 1, effective May 14.

Editor's note: Subsection (6)(a) provided for the repeal of subsections (1) to (5) and (5.5), effective July 1, 2008. (See L. 2006, p. 1626.) Subsection (5.3)(b) provided for the repeal of subsection (5.3), effective July 1, 2009. (See L. 2008, p. 809.) Subsection (6)(b) provided for the repeal of subsection (6), effective July 1, 2009. (See L. 2008, p. 809.)

10-16-132. Study of factors driving health care costs in Pueblo county - repeal. (Repealed)

Source: L. 2007: Entire section added, p. 2101, § 1, effective June 4. **L. 2008:** (2)(c) amended, p. 1881, § 14, effective August 5.

Editor's note: Subsection (4) provided for the repeal of this section, effective January 15, 2009. (See L. 2007, p. 2101.)

10-16-133. Health carrier information disclosure - website - insurance producer fees and disclosure requirements - legislative declaration - rules. (1) The general assembly finds and determines that consumers deserve to know the quality and cost of their health-care insurance. Health-care insurance transparency provides consumers with the information necessary, and the incentive, to choose health plans based on cost and quality. The general

assembly further finds that providing reliable cost and quality information about health-care insurance empowers consumer choice and that consumer choice creates incentives at all levels and motivates the entire system to provide better care and benefits for less money. Therefore it is the intent of the general assembly to make information regarding the costs of health-care insurance readily available to consumers through the division of insurance.

(2) The commissioner shall implement and maintain a consumer guide on the division of insurance website that is easily accessible and available to consumers regarding each carrier authorized to do business in this state. The website shall:

(a) Be derived from the information that each carrier is required to file with the division, except for records that are not open to public inspection pursuant to part 2 of article 72 of title 24, C.R.S.;

(b) Include such information as the commissioner determines, in his or her discretion and after soliciting input from interested parties, to be useful to consumers and purchasers of health-care insurance; except that records that are not open to public inspection pursuant to part 2 of article 72 of title 24, C.R.S., shall not be included; and

(c) Include a link to the division's complaint form for use by consumers to file a complaint against a carrier and a link to the division's complaint index so that consumers may access information regarding complaints against carriers.

(3) The commissioner is authorized to include additional health plan and quality information on the website from state or nationally recognized organizations that measure performance of health benefit plans.

(4) The commissioner shall consider alternative methods of making the consumer guide accessible to consumers who do not have internet access.

(5) (a) An insurance producer licensed pursuant to part 4 of article 2 of this title 10 who solicits or negotiates an application for health-care insurance on behalf of a carrier shall disclose to the person purchasing the plan that the insurance producer will receive a commission from the carrier. The insurance producer shall provide the consumer with the standard compensation schedule for the product being sold. Any change to the insurance producer's compensation from the initial disclosure to the time of purchase shall be disclosed by the insurance producer to the purchaser at or before the time of sale.

(b) An insurance producer may charge a client a fee for advising the client on the selection of an individual health benefit plan only if the producer:

(I) Will not receive a commission from the insurer offering the individual health benefit plan selected by the client; and

(II) Provides a written disclosure to the client if the producer will charge a fee for the service.

(c) The commissioner shall promulgate reasonable rules that are necessary or proper for implementing and administering this subsection (5). The rules shall include a prohibition on an insurance producer charging a fee to assist a client to enroll in medicaid, as defined in section 10-22-103 (8), or the children's basic health plan, as defined in section 25.5-8-103 (2).

(6) (a) A carrier offering individual health benefit plans or short-term limited duration health insurance policies shall disclose to the covered person the amount of compensation associated with plan selection and enrollment consistent with the federal "No Surprises Act", Pub.L. 116-260, as amended.

(b) The commissioner shall promulgate rules to implement the carrier disclosure requirements under this subsection (6).

Source: L. 2008: Entire section added, p. 2067, § 1, effective January 1, 2009. **L. 2018:** (5) amended, (SB 18-136), ch. 118, p. 817, § 1, effective August 8. **L. 2022:** (6) added, (HB 22-1284), ch. 446, p. 3151, § 7, effective August 10.

10-16-134. Health-care transparency - information required - website - definition. (Repealed)

Source: L. 2008: Entire section added, p. 1265, § 4, effective May 27. **L. 2024:** Entire section repealed, (SB 24-135), ch. 34, p. 105, § 1, effective March 22.

10-16-135. Health coverage plan information cards - rules - standardization - contents. (1) (a) **[*Editor's note: This version of the introductory portion of subsection (1)(a) is effective until January 1, 2026.*]** The commissioner shall adopt rules requiring every carrier providing a health benefit plan to issue to covered persons to whom a health benefit plan identification card is issued a standardized printed card containing plan information. To the extent possible, the rules shall incorporate and not conflict with the requirements of section 10-16-124 regarding prescription information cards. The commissioner shall adopt initial rules by October 31, 2008, that describe the format of a standardized, printed card to be issued by carriers to persons covered under a health benefit plan to whom health benefit plan identification cards are issued. The rules establishing the format for the printed card shall include a standard size, shall require the card to be legible and photocopied, and shall delineate the information to be contained on the card, including, but not limited to, the following information, as applicable:

(1) (a) **[*Editor's note: This version of the introductory portion of subsection (1)(a) is effective January 1, 2026.*]** The commissioner shall adopt rules requiring every carrier providing a health benefit plan to issue to covered persons to whom a health benefit plan identification card is issued a standardized printed or electronic card containing plan information. To the extent possible, the rules shall incorporate and not conflict with the requirements of section 10-16-124 regarding prescription information cards. The format for the printed or electronic card shall include a standard size, shall require the card to be legible and photocopied, and shall delineate the information to be contained on the card, including but not limited to the following information, as applicable:

(I) The covered person's name and the applicable plan number;

(II) Copayment and deductible amounts for the most commonly used health-care services;

(III) Contact information for the carrier or health benefit plan administrator; and

(IV) An indication of whether the health benefit plan is regulated by the state.

(b) **[*Editor's note: This version of subsection (1)(b) is effective until January 1, 2026.*]** The rules adopted pursuant to paragraph (a) of this subsection (1) shall require all carriers to issue a standardized printed card to a covered person to whom a health benefit plan identification card is issued upon the purchase or renewal of or enrollment in a plan on or after July 1, 2009. No later than July 1, 2010, all carriers shall issue the standardized, printed card to covered persons to whom health benefit plan identification cards are issued.

(b) **[*Editor's note: This version of subsection (1)(b) is effective January 1, 2026.*]** A carrier shall issue a standardized printed or electronic card to a covered person to whom a health benefit plan is issued upon the purchase or renewal of or enrollment in a plan.

(c) **[*Editor's note: This version of subsection (1)(c) is effective until January 1, 2026.*]** Nothing in this section shall preclude a carrier from including information on the standardized printed cards that is in addition to the information required to be included on the card pursuant to rules adopted pursuant to this section.

(c) **[*Editor's note: This version of subsection (1)(c) is effective January 1, 2026.*]** Nothing in this section shall preclude a carrier from including information on the standardized printed or electronic cards that is in addition to the information required to be included on the card pursuant to rules adopted pursuant to this section.

(d) **[*Editor's note: Subsection (1)(d) is effective January 1, 2026.*]** A carrier shall provide a printed card to a covered person upon request.

(e) **[*Editor's note: Subsection (1)(e) is effective January 1, 2026.*]** The commissioner may adopt rules to implement this section.

(2) (a) No later than thirty days after June 3, 2008, the commissioner, in consultation with the director of the division of professions and occupations in the department of regulatory agencies and the executive director of the department of public health and environment, shall establish a work group comprised of representatives of the divisions of insurance and registrations in the department of regulatory agencies; the departments of public health and environment, personnel, and health care policy and financing; the governor's office of information technology; carriers; providers, including hospitals, physicians, and pharmacists; private businesses; consumers; and other stakeholders deemed appropriate by the commissioner. The work group shall:

(I) Make recommendations on standards for technology and tools through which information may be electronically recognized, exchanged, or transmitted between carriers and providers, which standards shall conform to any standards adopted by a nonprofit organization that sets relevant national technical standards;

(II) Make recommendations as to the specific information that such technology and tools should be able to electronically exchange or transmit;

(III) Make recommendations to simplify eligibility and coverage verification through electronic data interchange utilizing swipe card or other appropriate technology;

(IV) Make recommendations regarding eligibility notification, preauthorization, or service notification and retroactive denial through electronic data interchange using swipe card or other appropriate technology;

(V) Make recommendations regarding how to incorporate the requirements of section 10-16-124 pertaining to uniform prescription drug information as part of the technology and tools for electronically recognizing, exchanging, or transmitting information between carriers and providers;

(VI) Make recommendations regarding whether, once electronic data interchange technology and tools are fully implemented, standardized, printed cards are necessary and, if so, what information needs to be included on the printed cards;

(VII) Make recommendations regarding when such technology could be implemented for medical assistance programs, as defined in sections 25.5-1-103 and 25.5-4-103, C.R.S.; and

(VIII) Make recommendations, if the work group so chooses, to create a pilot program for initial use of the recommended technology and tools.

(b) The work group established pursuant to paragraph (a) of this subsection (2) shall report its recommendations to the commissioner no later than six months after its first meeting; except that, if the work group is unable to complete its duties in six months, it may request that the commissioner extend the deadline by not more than an additional six months.

(c) After receipt of the work group's recommendations, the commissioner shall adopt rules to implement a standardized electronic swipe card or other appropriate technology to be used by carriers, providers, and covered persons under a health benefit plan to allow access to information regarding the applicable coverage under the plan. Carriers shall implement the new technology no later than two years after the effective date of the rules adopted pursuant to this paragraph (c); except that, if the work group concludes that carriers are unable to fully implement the technology by the deadline, the work group may recommend that the commissioner grant an extension of not more than six months for full implementation of the requirements of such rules.

(3) The rules adopted by the commissioner pursuant to this section shall conform to applicable federal guidelines on standardized claims attachment forms once such federal guidelines are adopted.

(4) The commissioner shall amend, modify, reenact, update, or otherwise revise the rules adopted pursuant to this section as necessary to reflect the most current technology available that will allow real-time data exchange, benefits eligibility, coverage determinations, and other appropriate provider-carrier transactions.

(5) Licensed or certified hospitals and physicians licensed pursuant to article 240 of title 12 shall use the standardized, printed card provided to covered persons and children's basic health plan enrollees and, once implemented, shall use the standardized electronic technology for accessing information about the coverage available under a health benefit plan or the children's basic health plan for a covered person or enrollee to whom health-care services are or will be provided by the hospital or physician.

(6) A carrier or provider located in a rural area of the state, as determined by the commissioner, may apply to the commissioner for, and the commissioner may grant, an extension of any of the deadlines imposed by this section if meeting a particular deadline would impose a financial hardship on the rural carrier or provider. The commissioner may require the rural carrier or provider to submit documentation supporting the financial hardship claim.

(7) The commissioner shall adopt rules that require each carrier that provides a dental coverage plan, as defined in section 10-16-165 (1)(b), to issue to covered persons to whom a dental coverage plan identification card is issued a standardized written or virtual card containing plan information. To the extent possible, the rules must incorporate and not conflict with the requirements of section 10-16-124 regarding prescription information cards. The commissioner shall adopt rules by March 31, 2024, that describe the format of the standardized card to be issued by carriers. The rules establishing the format for the card must include a standard size, must require the card to be legible and photocopied, and must delineate the information to be contained on the card, including the following, as applicable:

(a) The covered person's name and the applicable plan number;

(b) Contact information for the carrier or dental coverage plan administrator; and

(c) An indication of whether the dental coverage plan is regulated by the state of Colorado.

Source: L. 2008: Entire section added, p. 2008, § 1, effective June 3. **L. 2019:** (5) amended, (HB 19-1172), ch. 136, p. 1655, § 49, effective October 1. **L. 2023:** (7) added, (SB 23-179), ch. 332, p. 1993, § 4, effective August 7. **L. 2025:** IP(1)(a), (1)(b), and (1)(c) amended and (1)(d) and (1)(e) added, (SB 25-010), ch. 11, p. 25, § 1, effective January 1, 2026.

Editor's note: Section 3(2) of chapter 11 (SB 25-010), Session Laws of Colorado 2025, provides that the act changing this section applies to conduct occurring on or after January 1, 2026.

Cross references: For the legislative declaration in SB 23-179, see section 1 of chapter 332, Session Laws of Colorado 2023.

10-16-136. Wellness and prevention programs - individual and small group health coverage plans - voluntary participation - incentives or rewards - rules - definitions - legislative declaration - repeal. (Repealed)

Source: L. 2009: Entire section added, (HB 09-1012), ch. 188, p. 819, § 1, effective July 1. **L. 2010:** (1), (2)(a), (2)(b), (3)(a), (3)(c), (3)(d), and (5) amended and (3)(f), (3.5), (3.7), (6.5), (6.7), (7)(a.5), and (8) added, (HB 10-1160), ch. 283, pp. 1321, 1326, 1327, §§ 1, 2, 3, effective July 1. **L. 2013:** (2)(a), (3.5)(a), and (5)(b) amended and (5)(a)(III)(A) repealed, (HB 13-1266), ch. 217, p. 973, § 24, effective May 13; (7)(a) repealed, (HB 13-1115), ch. 338, p. 1972, § 10, effective March 31, 2015.

Editor's note: Subsection (8) provided for the repeal of this section, effective July 1, 2015. (See L. 2010, p. 1321.)

10-16-137. Policy forms - explanation of benefits - standardization of forms - rules. (1) The commissioner shall convene a group of stakeholders, including carriers, providers, and consumers, to develop a standardized format for the following regarding health benefit plans, limited benefit health insurance, and dental plans:

(a) Section names and the placement of those sections in the policy forms issued by all carriers; and

(b) The required information for carriers to provide on an explanation of benefits form sent to covered persons or providers making a claim for benefits under a health benefit plan, limited benefit health insurance, or dental plan.

(2) The commissioner shall adopt rules after considering the input from carriers, providers, consumers, and other stakeholders in developing the standardized format for policy forms and explanation of benefits forms. The rules shall apply to health benefit plans, limited benefit health insurance, and dental plans issued or delivered on or after January 1, 2012.

Source: L. 2010: Entire section added, (HB 10-1004), ch. 141, p. 477, § 1, effective August 11.

10-16-138. Pathology services - direct billing required. (1) A clinical laboratory or physician that is located in this state or in another state, and that provides anatomic pathology services for patients in this state, shall present or cause to be presented a claim, bill, or demand for payment for these services only to:

(a) The patient;

(b) The responsible insurance carrier or other third-party payer;

(c) The hospital, public health clinic, or nonprofit health clinic ordering such services;

(d) The referring laboratory, excluding a laboratory of a physician's office or group practice that does not perform the professional component of the anatomic pathology service for which such claim, bill, or demand is presented; or

(e) A governmental agency or its specified public or private agent, agency, or organization on behalf of the recipient of the services.

(2) Except for a physician at a referring laboratory that has been billed pursuant to subsection (6) of this section, no licensed practitioner in the state may, directly or indirectly, charge, bill, or otherwise solicit payment for anatomic pathology services unless the services were rendered personally by the licensed practitioner or under the licensed practitioner's direct supervision in accordance with section 353 of the "Public Health Service Act", 42 U.S.C. sec. 263a.

(3) A patient, insurer, third-party payer, hospital, public health clinic, or nonprofit health clinic is not required to reimburse a licensed practitioner for charges or claims submitted in violation of this section.

(4) Nothing in this section:

(a) Mandates the assignment of benefits for anatomic pathology services; or

(b) Prohibits a group practice, as defined in 42 U.S.C. sec. 1395nn (h)(4)(A)(i) to (iv), from billing for anatomic pathology services when a physician in the group practice performs or supervises anatomic pathology services in a laboratory that is owned and operated by at least one member of the group practice.

(5) For purposes of this section, "anatomic pathology services" means:

(a) Histopathology or surgical pathology, meaning the gross and microscopic examination performed by a physician or under the supervision of a physician, including histologic processing;

(b) Cytopathology, meaning the microscopic examination of cells from the following:

(I) Fluids;

(II) Aspirates;

(III) Washings;

(IV) Brushings; or

(V) Smears, including the pap test examination performed by a physician or under the supervision of a physician;

(c) Hematology, meaning the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician, or under the supervision of a physician, and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist;

(d) Subcellular pathology or molecular pathology, meaning the assessment of a patient specimen for the detection, localization, measurement, or analysis of one or more protein or nucleic acid targets; and

(e) Blood-banking services performed by pathologists.

(6) This section does not prohibit billing of a referring laboratory for anatomic pathology services in instances where a sample or samples must be sent to another physician or laboratory for consultation or histologic processing. The term "referring laboratory" does not include a laboratory of a physician's office or group practice that does not perform the professional component of the anatomic pathology service involved.

(7) A person who receives a bill for an anatomic pathology service made in knowing and willful violation of this section may maintain an action to recover the actual amount paid for the bill.

Source: L. 2012: Entire section added, (HB 12-1221), ch. 41, p. 142, § 1, effective January 1, 2013.

10-16-139. Access to care - rules - definitions. (1) **Access to obstetricians and gynecologists.** A health benefit plan that is delivered, issued, renewed, or reinstated in this state on or after January 1, 2014, that provides coverage for reproductive health or gynecological care shall not be delivered, issued, renewed, or reinstated unless the plan provides a woman covered by the plan direct access to an obstetrician, a gynecologist, a physician assistant authorized under section 12-240-107 (6), an advanced practice registered nurse who is a certified nurse midwife pursuant to section 12-255-111, or a certified midwife licensed pursuant to section 12-255-111.5, participating and available under the plan for her reproductive health care or gynecological care.

(2) **Eye care services.** (a) A health coverage plan or managed care plan that provides coverage for eye care services shall not be issued or renewed after January 1, 2001, by any entity subject to part 2, 3, or 4 of this article unless the health coverage plan or managed care plan:

(I) Provides a covered person direct access to any eye care provider participating and available under the plan or through its eye care services intermediary for eye care services;

(II) Ensures that all eye care providers on a health coverage plan or managed care plan are annually included on any publicly accessible list of participating providers for the health coverage plan or managed care plan; and

(III) Allows each eye care provider on a health coverage plan or managed care plan panel to furnish covered eye care services to covered persons without discrimination between classes of eye care providers and to provide the services as permitted by their license.

(b) A carrier offering a health coverage plan or managed care plan shall not:

(I) Impose a deductible or coinsurance for eye care services that is greater than the deductible or coinsurance imposed for other medical services under the health coverage plan or managed care plan;

(II) Require an eye care provider to hold hospital privileges as a condition of participation as a provider under the health coverage plan or managed care plan, unless an eye care provider is licensed pursuant to article 240 of title 12; or

(III) Impose penalties upon primary care providers as a result of the direct access provisions of this section.

(c) This subsection (2) does not:

(I) Create coverage for any health-care service that is not otherwise covered under the terms of the health coverage plan or managed care plan;

(II) Require a health coverage plan or managed care plan to include as a participating provider every willing provider or health professional who meets the terms and conditions of the health coverage plan or managed care plan;

(III) Prevent a covered person from seeking eye care services from the covered person's primary care provider in accordance with the terms of the covered person's health coverage plan or managed care plan;

(IV) Increase or decrease the scope of the practice of optometry as defined in section 12-275-103;

(V) Require eye care services to be provided in a hospital or similar medical facility; or

(VI) Prohibit a health coverage plan or managed care plan from requiring a covered person to receive a referral or prior authorization from a primary care provider for any subsequent surgical procedures.

(d) As used in this subsection (2), unless the context otherwise requires:

(I) "Eye care provider" means a participating provider who is an optometrist licensed to practice optometry pursuant to article 275 of title 12 or an ophthalmologist licensed to practice medicine pursuant to article 240 of title 12.

(II) "Eye care services" means those health-care services related to the examination, diagnosis, treatment, and management of conditions and diseases of the eye and related structures that a health coverage plan or managed care plan is obligated to pay, reimburse, arrange, or provide for covered persons or organizations as specified by a health coverage plan or managed care plan, excluding those health-care services rendered in conjunction with a routine vision examination or the filling of prescriptions for corrective eyewear.

(3) **Treatment of intractable pain.** (a) A service or indemnity contract issued or renewed on or after January 1, 1998, by any entity subject to part 2, 3, or 4 of this article 16 shall disclose in the contract and in information on coverage presented to consumers whether the health coverage plan or managed care plan provides coverage for treatment of intractable pain. If the contract is silent on coverage of intractable pain, the contract is presumed to offer coverage for the treatment of intractable pain. If the contract is silent or if the plan specifically includes coverage for the treatment of intractable pain, the plan shall provide access to the treatment for any individual covered by the plan either:

(I) By a primary care physician or physician assistant authorized under section 12-240-107 (6), so long as the physician or physician assistant has demonstrated interest and documented experience in pain management and has a practice that includes up-to-date pain treatment;

(II) By providing direct access to a pain management specialist located within this state and participating in and available under the plan; or

(III) By having procedures in place that ensure that, if the individual requests a timely referral for intractable pain management to a pain management specialist participating in and available under the plan, the carrier shall not unreasonably deny the request for referral.

(b) The commissioner may promulgate rules to implement and administer this subsection (3) that include the following issues:

(I) What constitutes a timely referral;

(II) Circumstances, practices, policies, contract provisions, or actions that constitute an undue or unreasonable interference with the ability of an individual to secure a referral or reauthorization for continuing care;

(III) The process for issuing a denial of a request, including the means by which an individual may receive notice of a denial and the reasons for the denial in writing;

(IV) Actions that constitute improper penalties imposed upon a primary care physician or physician assistant authorized under section 12-240-107 (6) as a result of referrals made pursuant to this section; and

(V) Such other issues as the commissioner deems necessary.

(c) For purposes of this subsection (3), "intractable pain" means a pain state in which the cause of the pain cannot be removed and for which, in the generally accepted course of medical practice, relief or cure of the cause of the pain is impossible or has not been found after reasonable efforts, including evaluation by the attending physician or physician assistant authorized under section 12-240-107 (6) and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.

(4) **Access to pediatric care.** (a) If a carrier offering an individual or small employer health benefit plan requires or provides for the designation of a participating primary health-care professional, the carrier shall permit the parent or legal guardian of each covered person who is a child to designate any participating physician or physician assistant authorized under section 12-240-107 (6) who specializes in pediatrics as the child's primary health-care professional if the pediatrician or physician assistant is available to accept the child.

(b) The provisions of paragraph (a) of this subsection (4) do not waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

(5) **Annual behavioral health screenings.** A health benefit plan that is issued or renewed in this state on or after January 1, 2020, that provides coverage for an annual physical examination as a preventive health-care service pursuant to section 10-16-104 (18) shall include coverage and reimbursement for behavioral health screenings using a validated screening tool for behavioral health, which coverage and reimbursement is no less extensive than the coverage and reimbursement for the annual physical examination.

Source: L. 2013: Entire section added with relocations, (HB 13-1266), ch. 217, p. 975, § 25, effective May 13. **L. 2016:** (1), (3)(a)(I), (3)(b)(IV), (3)(c), and (4)(a) amended, (SB 16-158), ch. 204, p. 722, § 6, effective August 10. **L. 2019:** (5) added, (HB 19-1269), ch. 195, p. 2129, § 8, effective May 16; (1), (2)(b)(II), (2)(c)(IV), (2)(d)(I), IP(3)(a), (3)(a)(I), (3)(b)(IV), (3)(c), and (4)(a) amended, (HB 19-1172), ch. 136, p. 1655, § 50, effective October 1. **L. 2023:** (1) amended, (SB 23-167), ch. 261, p. 1546, § 52, effective May 25.

Editor's note: Subsections (1), (2), and (3) are similar to former § 10-16-107 (5)(a), (5.5), and (7), respectively, as they existed prior to 2013.

Cross references: (1) For the legislative declaration in SB 16-158, see section 1 of chapter 204, Session Laws of Colorado 2016.

(2) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

10-16-140. Grace periods - premium payments - rules. (1) For individual and small employer health benefit plans issued or renewed for coverage to begin on or after January 1,

2014, for persons receiving a subsidy under the federal act, the commissioner shall establish, by rule that complies with federal law, a requirement that all individual and small employer health benefit plans contain a provision specifying that the policyholder is entitled to a three-month grace period for the payment of any premium due, other than the first premium, during which period the plan continues in force unless the policyholder submits written notice to the carrier, prior to discontinuance of the plan in accordance with the terms of the plan, that the policyholder is discontinuing the coverage. In accordance with federal law, the commissioner's rule may provide that the policyholder is liable to the carrier for the payment of a pro rata premium for the time the coverage was in force during the grace period.

(2) For individual and small employer health benefit plans issued or renewed for coverage to begin on or after January 1, 2014, for persons who are not receiving a subsidy under the federal act, the commissioner shall adopt a rule requiring a thirty-one-day grace period for the payment of any premium due other than the first premium.

(3) If the covered person fails to pay all or part of the premium, the carrier shall notify the covered person of the nonpayment of premium within the grace period established pursuant to this section and in accordance with section 10-16-222, 10-16-325, or 10-16-429, as applicable.

(4) The commissioner may adopt rules as necessary to implement and administer this section.

Source: L. 2013: Entire section added, (HB 13-1266), ch. 217, p. 977, § 26, effective May 13.

10-16-141. Medication synchronization services - cost sharing for partial refills - dispensing fees. (1) A carrier offering an individual or group health coverage plan in this state that provides prescription drug coverage shall offer, as part of the plan, medication synchronization services developed by the carrier that allow for the alignment of refill dates for a covered person's prescription drugs that are covered benefits.

(2) Under its medication synchronization services, a carrier shall:

(a) Not charge an amount in excess of the otherwise applicable copayment amount under the health coverage plan for dispensing a prescription drug in a quantity that is less than the prescribed amount if:

(I) The pharmacy dispenses the prescription drug in accordance with the medication synchronization services offered under the health coverage plan; and

(II) A network pharmacy dispenses the prescription drug; and

(b) Provide a full dispensing fee to the pharmacy that dispenses the medication to the covered person.

Source: L. 2014: Entire section added, (HB 14-1359), ch. 221, p. 828, § 1, effective May 17.

10-16-142. Physical rehabilitation services - copayments and coinsurance - research. (1) The Colorado commission on affordable health care created in section 25-46-103, C.R.S., shall conduct a study concerning the costs, including patient cost sharing for physical rehabilitation services. The study shall analyze costs to the health-care system, including payers

and individual patients, as well as whether patient cost sharing creates barriers to the effective use of physical rehabilitation services.

(2) On or before November 1, 2015, the commission shall report its findings to the health and human services committee of the senate and the public health care and human services committee and the health, insurance, and environment committee of the house of representatives.

(3) For the purposes of this section, "physical rehabilitation services" means physical therapy, occupational therapy, or chiropractic services for the treatment of a person who has sustained an illness, medical condition, or injury, with the goal of returning the person to his or her prior skill and function level or maintaining the person's current skill and function level.

Source: L. 2015: Entire section added, (HB 15-1083), ch. 321, p. 1305, § 1, effective June 5.

10-16-143. Single geographic rating area - individual plans - study - report - repeal. (Repealed)

Source: L. 2016: Entire section added, (HB 16-1336), ch. 168, p. 533, § 1, effective May 17.

Editor's note: Subsection (3) provided for the repeal of this section, effective December 31, 2016. (See L. 2016, p. 533.)

10-16-143.5. Pharmacy reimbursement - substance use disorders - injections - patient counseling. (1) If a pharmacy has entered into a collaborative pharmacy practice agreement with one or more physicians pursuant to section 12-280-602 to administer injectable antagonist medication for medication-assisted treatment for substance use disorders, the pharmacy administering the drug shall receive an enhanced dispensing fee.

(2) If a pharmacy dispenses an opioid that is a schedule II or schedule III drug pursuant to section 18-18-204 or 18-18-205 to a patient who has not previously received an opioid prescription and the pharmacy provides counseling concerning the risk of opioids to the patient, the dispensing pharmacy shall receive an enhanced dispensing fee.

(3) Subsection (2) of this section does not require a carrier to contract with a pharmacy or pharmacist willing to abide by the terms and conditions for participation established by the health benefit plan or carrier.

Source: L. 2018: Entire section added, (HB 18-1007), ch. 225, p. 1432, § 4, effective January 1, 2019. **L. 2019:** Entire section amended, (SB 19-228), ch. 276, p. 2601, § 1, effective May 23; entire section amended, (HB 19-1172), ch. 136, p. 1657, § 51, effective October 1.

Editor's note: Amendments to this section by SB 19-228 and HB 19-1172 were harmonized.

10-16-144. Health-care services provided by pharmacists. (1) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that

provides hospital, surgical, or medical expense insurance may provide coverage for health-care services under a specific treatment protocol provided by a pharmacist if:

(a) The pharmacist meets the requirements in part 6 of article 280 of title 12;

(b) The health benefit plan provides coverage for the same service provided by a licensed physician or an advanced practice registered nurse;

(c) The pharmacist is included in the health benefit plan's network of participating providers; and

(d) A reimbursement rate has been successfully negotiated in good faith between the pharmacist and the health plan.

(2) (a) A health benefit plan described in subsection (1) of this section shall provide coverage for health-care services provided by a pharmacist within a health professional shortage area, as defined in 42 U.S.C. sec. 254e, if the conditions specified in subsection (1) of this section are met.

(b) This subsection (2) does not require a carrier to contract with a pharmacy or pharmacist willing to abide by the terms and conditions for participation established by the health benefit plan or carrier.

(3) (a) Notwithstanding the provisions of subsection (1) of this section to the contrary, a health benefit plan described in subsection (1) of this section that provides treatment for substance use disorders shall reimburse a licensed pharmacist acting within the licensed pharmacist's scope of practice, and in accordance with the requirements in part 6 of article 280 of title 12, for the provision of medication-assisted treatment services if the health benefit plan provides coverage for the same services provided by a licensed physician or an advanced practice registered nurse.

(b) A health benefit plan reimbursing a licensed pharmacist pursuant to subsection (3)(a) of this section shall reimburse a licensed pharmacist at the same rate that the health benefit plan reimburses a licensed physician or an advanced practice registered nurse within the health benefit plan's network of participating providers for the same services.

Source: L. 2016: Entire section added, (SB 16-135), ch. 239, p. 981, § 1, effective August 10. **L. 2018:** (2) added, (HB 18-1112), ch. 112, p. 806, § 1, effective August 8. **L. 2019:** (1)(a) amended, (HB 19-1172), ch. 136, p. 1657, § 52, effective October 1. **L. 2024:** (3) added, (HB 24-1045), ch. 470, p. 3277, § 2, effective August 7.

10-16-145. Step therapy - limitations - exceptions - definitions - rules. (1) As used in this section:

(a) "Biosimilar" has the meaning set forth in 42 U.S.C. sec. 262 (i)(2).

(b) "Clinical practice guidelines" means a systematically developed statement to assist providers and covered persons in making decisions about appropriate health care for specific clinical circumstances and conditions.

(c) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a carrier or private utilization review organization to determine the medical necessity and appropriateness of the provision of health-care services. Clinical review criteria must not be more restrictive than the FDA's indication for a specific drug or health-care service.

(d) "Exigent circumstance" means a circumstance in which a covered person is suffering from a health condition that may seriously jeopardize the covered person's life, health, or ability to regain maximum functions.

(e) "Medical necessity" has the same meaning as set forth in section 10-16-112.5.

(f) "Private utilization review organization" or "organization" has the same meaning as set forth in section 10-16-112 (1)(a).

(f.5) "Serious mental illness" means the following psychiatric illnesses, as defined by the American Psychiatric Association in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders:

(I) Bipolar disorders (hypomanic, manic, depressive, and mixed);

(II) Depression in childhood and adolescence;

(III) Major depressive disorders (single episode or recurrent);

(IV) Obsessive-compulsive disorders;

(V) Paranoid and other psychotic disorders;

(VI) Schizoaffective disorders (bipolar or depressive); and

(VII) Schizophrenia.

(g) "Step therapy" means a protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health-care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

(2) If a carrier, a private utilization review organization, or a PBM requires step therapy, the carrier, organization, or PBM shall use clinical review criteria to establish the protocol for step therapy based on clinical practice guidelines.

(3) A carrier, a private utilization review organization, or a PBM shall:

(a) Make the clinical review criteria and the step-therapy exemption process available on their websites; and

(b) Upon written request, provide all specific clinical review criteria and other clinical information relating to a covered person's particular condition or disease, including clinical review criteria relating to a step-therapy exception, to the requester.

(4) (a) A carrier, a private utilization review organization, or a PBM shall grant an exception to step therapy if the prescribing provider submits justification and supporting clinical documentation, if needed, that states:

(I) The provider attests that the required prescription drug is contraindicated or will likely cause an adverse reaction or harm to the covered person;

(II) The required prescription drug is ineffective based on the known clinical characteristics of the covered person and the known characteristics of the prescription drug regimen;

(III) The covered person has tried, while under the covered person's current or previous health benefit plan, the required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the use of the prescription drug by the covered person was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(IV) The covered person, while on the covered person's current or previous health benefit plan, is stable on a prescription drug selected by the prescribing provider for the medical

condition under consideration after undergoing step therapy or after having sought and received a step-therapy exception.

(b) (I) Except as provided in subsection (4)(b)(II) of this section, a carrier, an organization, or a PBM shall grant or deny a step-therapy exception request or an appeal of a denial of a request within:

(A) Three business days after receipt of the request; or

(B) In cases where exigent circumstances exist, within twenty-four hours after receipt of the request.

(II) If a request for a step-therapy exception or an appeal of a denial of a request is incomplete or if additional clinically relevant information is required, the carrier, organization, or PBM shall notify the prescribing provider within seventy-two hours after submission of the request, or within twenty-four hours after the submission of the request if exigent circumstances exist, that the request or appeal is incomplete or that additional clinically relevant information is required. The carrier, organization, or PBM must specify the additional information that is required in order to consider the step-therapy exception request or the appeal of the denial of the request pursuant to the criteria described in subsection (4)(a) of this section. Once the requested information is submitted to the carrier, organization, or PBM, the applicable period to grant or deny a step-therapy exception request or an appeal of a denial of a request, as specified in subsection (4)(b)(I) of this section, applies.

(III) If a carrier, an organization, or a PBM does not make a determination regarding the step-therapy exception request or the appeal of the denial of the request or does not make a request for additional or clinically relevant information within the required time, the step-therapy exception request or the appeal of the denial of the request is deemed granted.

(c) If the initial request for a step-therapy exception is denied, the carrier, organization, or PBM shall inform the covered person in writing that the covered person has the right to an internal or external review or an appeal of the adverse determination pursuant to sections 10-16-113 and 10-16-113.5.

(d) A carrier, an organization, or a PBM shall authorize coverage for the prescription drug prescribed by the covered person's prescribing provider when the step-therapy exception request is granted.

(4.5) With respect to a covered drug prescribed for serious mental illness:

(a) If, under a health benefit plan, a carrier, a private utilization review organization, or a PBM requires step therapy, the step therapy may only require a covered person to try one prescription drug other than the drug prescribed by the provider prior to providing coverage to the covered person for the drug prescribed by the covered person's provider.

(b) Notwithstanding subsection (4.5)(a) of this section, if a covered person's provider attests on a form established by the division that any of the criteria specified in subsections (4)(a)(I) to (4)(a)(IV) of this section are met, the carrier, private utilization review organization, or PBM must cover the drug prescribed by the covered person's provider without requiring step therapy.

(5) This section does not prohibit:

(a) A carrier, an organization, or a PBM from requiring a covered person to try a generic equivalent drug, a biosimilar drug, or an interchangeable biological product as defined by 42 U.S.C. sec. 262 (i)(3), unless the covered person or covered person's prescribing provider has

requested a step-therapy exception and the prescribed drug meets the criteria for a step-therapy exception specified in subsection (4)(a) of this section;

(b) A carrier, an organization, or a PBM from requiring a pharmacist to make substitutions of prescription drugs consistent with part 5 of article 280 of title 12; or

(c) A provider from prescribing a drug that is determined to be medically appropriate.

(6) The commissioner may promulgate rules to implement and enforce this section.

Source: L. 2017: Entire section added, (SB 17-203), ch. 296, p. 1627, § 1, effective September 1. **L. 2018:** (1) amended, (HB 18-1148), ch. 109, p. 799, § 1, effective January 1, 2019. **L. 2022:** Entire section R&RE, (HB 22-1370), ch. 184, p. 1230, § 3, effective August 10. **L. 2023:** (1)(f.5) and (4.5) added, (HB 23-1130), ch. 394, p. 2355, § 1, effective January 1, 2025.

10-16-145.5. Step therapy - prior authorization - prohibited - stage four advanced metastatic cancer - opioid prescription - definitions. (1) Notwithstanding section 10-16-145, a carrier that provides coverage under a health benefit plan for the treatment of stage four advanced metastatic cancer shall not limit or exclude coverage under the health benefit plan for a drug that is approved by the FDA and that is on the carrier's prescription drug formulary by mandating that a covered person with stage four advanced metastatic cancer undergo step therapy if the use of the approved drug is consistent with:

(a) The FDA-approved indication or the National Comprehensive Cancer Network drugs and biologics compendium indication for the treatment of stage four advanced metastatic cancer; or

(b) Peer-reviewed medical literature.

(2) Notwithstanding section 10-16-145, a carrier that provides prescription drug benefits shall:

(a) Provide coverage for at least one atypical opioid that has been approved by the FDA for the treatment of acute or chronic pain at the lowest tier of the carrier's drug formulary and not require step therapy or prior authorization, as defined in section 10-16-112.5 (7)(d), for that atypical opioid; and

(b) Not require step therapy for the prescription and use of any additional atypical opioid medications that have been approved by the FDA for the treatment of acute or chronic pain.

(3) As used in this section:

(a) "A typical opioid" means an opioid agonist with a documented safer side-effect profile and less risk of addiction than older opium-based medications.

(b) "Stage four advanced metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other parts of the body.

(c) "Step therapy" has the same meaning as specified in section 10-16-145 (1)(g).

Source: L. 2018: Entire section added, (HB 18-1148), ch. 109, p. 799, § 2, effective January 1, 2019. **L. 2021:** Entire section amended, (HB 21-1276), ch. 364, p. 2396, § 3, effective January 1, 2023. **L. 2022:** Entire section amended, (HB 22-1370), ch. 184, p. 1233, §§ 4, 5, effective August 10.

Cross references: For the legislative declaration in HB 21-1276, see section 1 of chapter 364, Session Laws of Colorado 2021.

10-16-146. Periodic updates to provider directory. Each carrier shall, at least every thirty days, update its provider directory as posted on the carrier's website in accordance with the information contained on the websites maintained by the applicable health-care prescriber board, as that term is defined in section 12-30-104, to remove a provider whose license has been revoked or suspended by the applicable health-care prescriber board.

Source: L. 2017: Entire section added, (HB 17-1165), ch. 377, p. 1944, § 1, effective June 6. **L. 2019:** Entire section amended, (HB 19-1172), ch. 136, p. 1657, § 53, effective October 1.

10-16-147. Parity reporting - commissioner - carriers - rules - examination of complaints. (1) (a) By June 1, 2020, and by each June 1 thereafter, the commissioner shall submit a written report to the health and insurance committee and the public health care and human services committee of the house of representatives, or their successor committees, and to the health and human services committee of the senate, or its successor committee, and provide a presentation of the report to those legislative committees before the next regular legislative session that follows submittal of the report, that:

(I) Specifies the methodology the commissioner uses to verify that carriers are complying with section 10-16-104 (5.5) and rules adopted under that section and with the MHPAEA, any regulations adopted pursuant to that act, or guidance related to compliance with and oversight of that act;

(II) Identifies market conduct examinations initiated, conducted, or completed during the preceding twelve months regarding compliance with section 10-16-104 (5.5) and rules adopted under that section and with the MHPAEA and regulations adopted under that act and summarizes the outcomes of those market conduct examinations;

(III) Details any educational or corrective actions the commissioner has taken to ensure carrier compliance with section 10-16-104 (5.5) and rules adopted under that section and with the MHPAEA and regulations adopted under that act.

(b) The commissioner shall ensure that the report is written in plain language and is made available to the public by, at a minimum, posting the report on the division's website.

(c) Notwithstanding section 24-1-136 (11)(a)(I), the reporting requirement specified in this section continues indefinitely.

(2) A carrier that offers a health benefit plan that is subject to section 10-16-104 (5.5) shall submit to the commissioner and make available to the public, by March 1, 2020, and by each March 1 thereafter, a report that contains the following information for the prior calendar year:

(a) Data that demonstrates parity compliance for adverse determinations regarding claims for behavioral, mental health, or substance use disorder services and includes the total number of adverse determinations for such claims;

(b) A description of the process used to develop or select:

(I) The medical necessity criteria used in determining benefits for behavioral, mental health, and substance use disorders; and

(II) The medical necessity criteria used in determining medical and surgical benefits;

(c) Identification of all nonquantitative treatment limitations that are applied to benefits for behavioral, mental health, and substance use disorders and to medical and surgical benefits within each classification of benefits; and

(d) (I) The results of analyses demonstrating that, for medical necessity criteria described in subsection (2)(b) of this section and for each nonquantitative treatment limitation identified in subsection (2)(c) of this section, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use disorders within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits.

(II) A carrier's report on the results of the analyses specified in this subsection (1)(d) must, at a minimum:

(A) Identify the factors used to determine whether a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for benefits for behavioral, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to design and apply each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits;

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for benefits for behavioral, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) Disclose the specific findings and conclusions reached by the carrier that the results of the analyses indicate that each health benefit plan offered by the carrier complies with section 10-16-104 (5.5) and the MHPAEA.

(3) The commissioner shall adopt rules as necessary to implement the reporting requirements of subsection (2) of this section, including rules to specify the form and manner of carrier reports.

(4) If the commissioner receives a complaint from the office of the ombudsman for behavioral health access to care established pursuant to part 3 of article 80 of title 27 that relates to a possible violation of section 10-16-104 (5.5) or the MHPAEA, the commissioner shall examine the complaint, as requested by the office, and shall report to the office in a timely manner any action taken by the commissioner related to the complaint.

Source: L. 2018: Entire section added, (HB 18-1357), ch. 252, p. 1552, § 3, effective August 8. **L. 2019:** IP(1)(a) and (2) amended and (3) and (4) added, (HB 19-1269), ch. 195, p. 2129, § 9, effective May 16.

Cross references: For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

10-16-148. Medication-assisted treatment - limitations on carriers - rules. (1) Notwithstanding any provision of law to the contrary, beginning January 1, 2020, a carrier that provides prescription drug benefits for the treatment of substance use disorders shall, for prescription medications that are on the carrier's formulary:

(a) Not impose prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders;

(b) Not impose any step therapy requirements as a prerequisite for coverage for a prescription medication approved by the FDA for the treatment of substance use disorders;

(c) Place at least one covered prescription medication approved by the FDA for the treatment of substance use disorders on the lowest tier of the drug formulary developed and maintained by the carrier; and

(d) Not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered.

(1.5) The commissioner, in consultation with the department of public health and environment, may promulgate rules or seek a revision to the prescription drug benefits required under the essential health benefits package concerning prescription medications that must be included on a carrier's formulary for medication-assisted treatment of substance use disorders.

(2) Repealed.

Source: L. 2019: Entire section added, (HB 19-1269), ch. 195, p. 2131, § 10, effective May 16. **L. 2020:** (1.5) added, (SB 20-007), ch. 286, p. 1391, § 8, effective July 13. **L. 2022:** (2) repealed, (HB 22-1264), ch. 126, p. 888, § 5, effective August 10.

Cross references: For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

10-16-149. Commissioner report - parity effects on premiums - repeal. (Repealed)

Source: L. 2019: Entire section added, (HB 19-1269), ch. 195, p. 2131, § 10, effective May 16.

Editor's note: Subsection (2) provided for the repeal of this section, effective March 1, 2023. (See L. 2019, p. 2131.)

10-16-150. Primary care payment reform collaborative - created - powers and duties - report - definition - repeal. (1) The commissioner shall convene a primary care payment reform collaborative to:

(a) Consult with the department of personnel, the executive director of the department of health care policy and financing, and the administrator of the Colorado all-payer health claims database described in section 25.5-1-204;

(b) Advise in the development of the affordability standards and targets for carrier investments in primary care established in accordance with section 10-16-107 (3.5);

(c) In coordination with the administrator of the all-payer health claims database described in section 25.5-1-204, analyze the percentage of medical expenses allocated to primary care:

(I) By health insurers;

(II) Under the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5; and

(III) Under the "Children's Basic Health Plan Act", article 8 of title 25.5;

(d) Develop a recommendation to the commissioner on the definition of primary care for the purposes of this section;

(e) Report on current health insurer practices and methods of reimbursement that direct greater health-care resources and investments toward health-care innovation and care improvement in primary care;

(f) Identify barriers to the adoption of alternative payment models by health insurers and providers, and develop recommendations to address the barriers;

(g) Develop recommendations to increase the use of alternative payment models that are not paid on a fee-for-service or per-claim basis to:

(I) Increase the investment in advanced primary care delivered by practices that are patient-centered medical homes as defined by national or state-recognized criteria or that have demonstrated the ability to provide high-quality primary care;

(II) Align primary care reimbursement by all consumers of primary care;

(III) Direct investment toward higher value primary care services with an aim toward reducing health disparities; and

(IV) Ensure the development and consideration of alternative payment models that are responsive to the needs of primary care delivery in pediatrics.

(h) Consider how to increase investment in advanced primary care without increasing costs to consumers or increasing the total cost of health care;

(i) Develop and share best practices and technical assistance with health insurers and consumers, which may include:

(I) Aligning quality metrics as developed in the state innovation model;

(II) Facilitating the integration of behavioral and physical primary care;

(III) Practice transformation; and

(IV) The delivery of advanced primary care that facilitates appropriate utilization of services in appropriate settings; and

(j) Annually review the alternative payment models developed by the division pursuant to section 10-16-157 (3) and provide the division with recommendations on the models.

(2) The commissioner shall invite representatives from the following to participate in the primary care payment reform collaborative:

(a) Health-care providers, including primary care providers and pediatric primary care providers;

(b) Health-care consumers;

(c) Employers that purchase health insurance for employees and employers that offer self-insured health benefit plans;

(d) Health insurers, including entities that contract with the department of health care policy and financing as managed care entities;

(e) The federal centers for medicare and medicaid services;

(f) The primary care office in the department of public health and environment created pursuant to section 25-1.5-403;

(g) The executive director of the department of health care policy and financing; and

(h) Experts in health insurance actuarial analysis.

(2.5) In carrying out the duties of subsection (1)(j) of this section, in addition to the members of the collaborative described in subsection (2) of this section, the commissioner shall include health insurers and health-care providers engaged in a range of alternative payment models.

(3) The commissioner shall convene the primary care payment reform collaborative on or before July 15, 2019.

(4) By February 15, 2023, and by each February 15 thereafter, the primary care payment reform collaborative shall publish primary care payment reform recommendations, informed by the primary care spending report prepared in accordance with section 25.5-1-204 (3)(c). The collaborative shall make the report available electronically to the general public.

(5) The division may seek, accept, and expend gifts, grants, or donations from private or public sources for the purposes of this section.

(6) As used in this section, "health insurer" means:

(a) A carrier that is subject to part 2, 3, or 4 of this article 16 and that is offering health benefit plans in Colorado; and

(b) A carrier that provides or administers a group benefit plan for state employees pursuant to part 6 of article 50 of title 24.

(7) This section is repealed, effective September 1, 2032. Before the repeal, the functions of the primary care payment reform collaborative are scheduled for review in accordance with section 2-3-1203.

Source: L. 2019: Entire section added, (HB 19-1233), ch. 194, p. 2119, § 2, effective May 16. **L. 2022:** (1)(h), (1)(i)(IV), and (4) amended and (1)(j) and (2.5) added, (HB 22-1325), ch. 181, p. 1208, § 2, effective August 10. **L. 2025:** (1)(g)(II), (1)(g)(III), (2)(a), and (7) amended and (1)(g)(IV) added, (SB 25-193), ch. 371, p. 2002, § 1, effective August 6.

Cross references: For the legislative declaration in HB 19-1233, see section 1 of chapter 194, Session Laws of Colorado 2019.

10-16-151. Cost sharing in prescription insulin drugs - limits - definition - rules. (1) As used in this section, unless the context otherwise requires, "prescription insulin drug" means a prescription drug, as defined in section 12-280-103 (42), that contains insulin and is used to treat diabetes.

(2) A carrier that provides coverage for prescription insulin drugs pursuant to the terms of a health coverage plan the carrier offers shall cap the total amount that a covered person is required to pay for all covered prescription insulin drugs at an amount not to exceed one hundred

dollars for the covered person's entire thirty-day supply of insulin, regardless of the amount or type of insulin needed to fill the covered person's prescription or the number of prescriptions.

(3) Nothing in this section prevents a carrier from reducing a covered person's cost sharing by an amount greater than the amount specified in subsection (2) of this section.

(4) The commissioner may use any of the commissioner's enforcement powers to obtain a carrier's compliance with this section.

(5) The commissioner may promulgate rules as necessary to implement and administer this section and to align with federal requirements.

Source: L. 2019: Entire section added, (HB 19-1216), ch. 248, p. 2419, § 2, effective August 2. **L. 2021:** (2) amended, (HB 21-1307), ch. 437, p. 2894, § 2, effective September 7.

Cross references: For the legislative declaration in HB 19-1216, see section 1 of chapter 248, Session Laws of Colorado 2019. For the legislative declaration in HB 21-1307, see section 1 of chapter 437, Session Laws of Colorado 2021.

10-16-152. HIV prevention and treatment medication - limitations on carriers - step therapy - prior authorization - study - repeal. (1) A carrier shall not require a covered person to undergo step therapy or to receive prior authorization before a pharmacist may, pursuant to section 12-280-125.7, prescribe or dispense an HIV prevention drug.

(2) Before July 1, 2027, a carrier shall not require a covered person to undergo step therapy or to receive prior authorization before a provider may, acting within the provider's scope of practice, prescribe or dispense any drug approved by the FDA and used for the treatment or prevention of HIV that is included on the carrier's prescription drug formulary as of March 1, 2023.

(3) (a) The division shall contract with one or more entities to conduct a study that includes qualitative patient and provider experience information and an actuarial review to consider the predicted cost and health impacts of removing the requirement for a covered person to undergo step therapy or to receive prior authorization before a provider may, acting within the provider's scope of practice, prescribe or dispense a drug for the treatment of HIV. In conducting the study, the entity contracted to perform the study must consult with community organizations led by people living with HIV. The division shall provide the completed study to the general assembly no later than October 1, 2026.

(b) This subsection (3) is repealed, effective July 1, 2027.

Source: L. 2020: Entire section added, (HB 20-1061), ch. 281, p. 1375, § 3, effective July 13. **L. 2023:** Entire section amended, (SB 23-189), ch. 69, p. 257, § 3, effective April 14.

10-16-153. Coverage for opioid antagonists provided by a hospital - definition. (1) As used in this section, unless the context otherwise requires, "opioid antagonist" has the same meaning as set forth in section 12-30-110 (7)(d).

(2) A carrier that provides coverage for opioid antagonists pursuant to the terms of a health coverage plan the carrier offers shall reimburse a hospital for the hospital's cost of an opioid antagonist if the hospital gives a covered person an opioid antagonist upon discharge from the hospital.

Source: L. 2020: Entire section added, (HB 20-1065), ch. 287, p. 1419, § 1, effective September 14. **L. 2024:** Entire section amended, (HB 24-1037), ch. 458, p. 3165, § 8, effective June 6.

Editor's note: This section was numbered as § 10-16-154 in HB 20-1065 but was renumbered on revision for ease of location.

10-16-154. Disclosures - physical therapists - occupational therapists - chiropractors - acupuncturists - patients - carrier prohibitions - enforcement. (1) A carrier that has a contract with a physical therapist, an occupational therapist, a chiropractor, or an acupuncturist shall not:

(a) Prohibit the physical therapist, occupational therapist, chiropractor, or acupuncturist from providing a covered person information on the amount of the covered person's financial responsibility for the physical therapy, occupational therapy, chiropractic services, or acupuncture services provided to the covered person;

(b) Penalize the physical therapist, occupational therapist, chiropractor, or acupuncturist for disclosing the information described in subsection (1)(a) of this section to a covered person or providing a more affordable alternative to a covered person; or

(c) Require the physical therapist, occupational therapist, chiropractor, or acupuncturist to charge an amount to a covered person or collect a copayment from a covered person that exceeds the total charges submitted to the carrier by the physical therapist, occupational therapist, chiropractor, or acupuncturist.

(2) If the commissioner determines that a carrier has not complied with this section, the commissioner shall require the carrier to develop and provide to the division for approval a corrective action plan or use any of the commissioner's enforcement powers under this title 10 to ensure the carrier's compliance with this section.

Source: L. 2021: Entire section added, (HB 21-1276), ch. 364, p. 2397, § 4, effective July 1.

Cross references: For the legislative declaration in HB 21-1276, see section 1 of chapter 364, Session Laws of Colorado 2021.

10-16-155. Actuarial reviews of proposed health-care legislation - division to contract with third parties - required considerations - confidentiality - limits on expenditures - rate filings - repeal. (1) On or before November 1, 2022, the division shall retain by contract one or more entities that have experience in actuarial reviews, health-care policy, and health equity, referred to in this section as the "contractors", for the purpose of performing actuarial reviews of legislative proposals that may impose a new health benefit coverage mandate on health benefit plans or reduce or eliminate coverage mandated under health benefit plans, referred to in this section as "legislative proposals". At least one of the contractors must be an actuary or an actuarial firm with experience in analyzing health insurance premiums. The contractors, under the direction of the division, shall conduct actuarial reviews of up to six legislative proposals, regardless of the number of legislative proposals that are requested for each regular legislative session by members of the general assembly.

(2) Before September 1, 2022, the division shall convene a meeting to obtain input and recommendations from stakeholders, including representatives of the health-care industry, consumer advocates, and other interested individuals, concerning the methodology for conducting the analysis described in subsection (4) of this section.

(3) (a) A member of the general assembly who requests an actuarial review of a legislative proposal shall submit the request to the division no later than September 1 of the year preceding the regular legislative session in which the legislative proposal will be proposed.

(b) For each regular legislative session:

(I) Up to two members of the majority party of the house of representatives may submit a request for an actuarial review. If more than two requests are submitted, the division shall notify the majority leader of the house of representatives, who shall select the two proposals that the contractors review.

(II) One member of the minority party of the house of representatives may submit up to one request for an actuarial review. If more than one request is submitted, the division shall notify the minority leader of the house of representatives, who shall select the proposal that the contractors review.

(III) Up to two members of the majority party of the senate may submit a request for an actuarial review. If more than two requests are submitted, the division shall notify the majority leader of the senate, who shall select the two proposals that the contractors review.

(IV) One member of the minority party of the senate may submit up to one request for an actuarial review. If more than one request is submitted, the division shall notify the minority leader of the senate, who shall select the proposal that the contractors review.

(c) On or before each September 15, the majority and minority leaders of the house of representatives and the senate shall notify the division, as may be necessary as described in this subsection (3), of the legislative proposals subject to review under subsection (1) of this section.

(4) An actuarial review performed by the contractors pursuant to this section must consider the predicted effects of the legislative proposal during the five and ten years immediately following the effective date of the legislative proposal, or during another time period following the effective date of the legislative proposal if such consideration is more actuarially feasible, including:

(a) An estimate of the number of Colorado residents who will be directly affected by the legislative proposal;

(b) Estimates of changes in the rates of utilization of specific health-care services that may result from the legislative proposal;

(c) Estimates concerning any changes in consumer cost sharing that would result from the legislative proposal;

(d) Estimates of any increases or decreases in premiums charged to covered persons or employers for health benefit plans offered in the individual, small group, and large group markets that would result from the legislative proposal;

(e) An estimate of the out-of-pocket health-care cost changes associated with the legislative proposal;

(f) An estimate of the potential long-term health-care cost changes associated with the legislative proposal;

(g) Identification of any potential health benefits for individuals or communities that would result from the legislative proposal; and

(h) To the extent practicable, the social and economic impacts of the legislative proposal.

(5) An actuarial review performed pursuant to this section must:

(a) Present the information described in subsection (4)(d) of this section in terms of percentage increase or decrease and in terms of per-member, per-month charges;

(b) Present the information described in subsection (4)(e) of this section in terms of dollar amounts;

(c) Provide, if available, information concerning who would benefit from any cost changes and health benefits from the legislative proposal, as identified in subsections (4)(c), (4)(e), (4)(f), (4)(g), and (4)(h) of this section, and any disproportionate effects that the legislative proposal would have on Coloradans, which information, if available, must be disaggregated, at a minimum, by race, ethnicity, sex, gender, and age; and

(d) Include, to the extent practicable, a qualitative analysis of the impacts of the legislative proposal. For the purposes of this subsection (5)(d), a member of the general assembly who requests an actuarial review of a legislative proposal pursuant to this section may designate one or more persons to provide data to the contractors in order to inform a qualitative analysis of the legislative proposal.

(6) In performing actuarial reviews of legislative proposals, the contractors may utilize data from the all-payer health claims database described in section 25.5-1-204, data collected from carriers, or data from other sources. Carriers shall provide information to, and otherwise cooperate with, the contractors and the division for the purposes of this section.

(7) The commissioner is not required to comply with the state "Procurement Code", articles 101 to 112 of title 24, for the purposes of hiring contractors by November 1, 2022, as described in subsection (1) of this section, or for contracting for the collection of data, but the commissioner shall comply with the state "Procurement Code" when hiring contractors or contracting for the collection of data after November 1, 2022.

(8) A request for an actuarial review pursuant to this section and the final report resulting from such a request shall be treated as confidential except by the member of the general assembly who made the request until the legislative proposal that is the subject of the actuarial review is introduced in the regular legislative session following the submission of the request for the actuarial review or, if no such legislative proposal is introduced, until after the end of the legislative session following the submission of the request.

(9) (a) Notwithstanding any other provision of this section to the contrary, the division shall not engage any contractor to perform an actuarial review as described in this section unless the division determines that there are adequate resources available within existing appropriations to compensate the contractor for the actuarial review.

(b) After July 1, 2025, the division shall use resources allocated for actuarial reviews of legislative proposals pursuant to this section for the review of rate filings filed with the commissioner pursuant to section 10-16-105.1 (3.5)(e).

(c) In the event that the division determines there are not adequate resources available within existing appropriations to compensate the contractor for an actuarial review in accordance with subsection (9)(a) of this section, the division shall prioritize resources to ensure that an actuarial review of the rate filings submitted to the commissioner pursuant to section 10-16-105.1 (3.5)(e) occurs before December 31, 2025.

(10) The division may seek, accept, and expend gifts, grants, and donations for the purposes of this section.

(11) This section is repealed, effective November 1, 2027.

Source: L. 2022: Entire section added, (SB 22-040), ch. 449, p. 3163, § 1, effective August 10. **L. 2024:** (9) amended, (SB 24-073), ch. 146, p. 591, § 3, effective May 1.

10-16-155.5. Actuarial review of doula services - report - definition. (1) The division shall contract with an independent entity to conduct an actuarial review of the potential health-care costs and benefits of including coverage for doula services for pregnant and postpartum persons covered by health benefit plans.

(2) The division shall present the results from the actuarial review conducted pursuant to subsection (1) of this section to the general assembly as part of the division's "SMART Act" presentation required by section 2-7-203 during state fiscal year 2024-25.

(3) As used in this section, unless the context otherwise requires, "doula" means a trained birth companion who provides personal, nonmedical support to pregnant and postpartum people and their families prior to childbirth, during labor and delivery, and during the postpartum period.

Source: L. 2023: Entire section added, (SB 23-288), ch. 279, p. 1655, § 3, effective May 30.

Cross references: For the legislative declaration in SB 23-288, see section 1 of chapter 279, Session Laws of Colorado 2023.

10-16-156. Prescription drugs - rebates - consumer cost reduction - point of sale - study - report - rules - definitions. (1) As used in this section, unless the context otherwise requires:

(a) "Discount" means price reductions or concessions, including base price concessions or other contractual agreements made by a manufacturer or its affiliate, that reduce payment or liability for prescription drugs, including a reduction in the total amount paid for prescription drugs, without regard to performance, volume, or utilization of the drugs, and all other compensation that reduces payment or liability for prescription drugs. "Discount" does not include a rebate.

(b) "Health insurer" means a carrier:

(I) As defined in section 10-16-102 (8); and

(II) As defined in section 24-50-603 (2).

(c) "Manufacturer" has the same meaning as set forth in section 10-16-1401 (16).

(d) "Prescription drug" has the same meaning as set forth in section 12-280-103 (42); except that the term includes only prescription drugs that are intended for human use.

(e) "Rebate" means all price concessions made by a manufacturer or its affiliate that accrue to a PBM or its health insurer client, including credits or incentives that are based on actual or estimated utilization of prescription drugs; that result in the placement of a prescription drug in a preferred drug list or formulary or preferred formulary position; or that are associated with claims administered on behalf of an insurer client. "Rebate" also includes credits,

incentives, refunds, and all other compensation that is performance-based. "Rebate" does not include a discount.

(2) For each health benefit plan issued or renewed on or after January 1, 2024, a health insurer shall ensure that one hundred percent of discounts received or to be received from a manufacturer in connection with dispensing or administering prescription drugs included in the health insurer's formulary, as demonstrated in the health insurer's rate filing pursuant to section 10-16-107, for that plan year are used to reduce costs.

(3) For each health benefit plan issued or renewed on or after January 1, 2024, a health insurer shall ensure that:

(a) One hundred percent of the estimated rebates received or to be received in connection with dispensing or administering prescription drugs included in the health insurer's formulary for that plan year are used to reduce policyholder costs;

(b) For small group and large group health benefit plans, all rebates are used to reduce employer or individual employee costs; and

(c) For individual health benefit plans, all rebates are used to reduce consumer premiums and out-of-pocket costs for prescription drugs and that health insurers will maximize the use of rebates to reduce consumer out-of-pocket costs at the point of sale, not to exceed the consumer's actual out-of-pocket costs for the prescription drug, if the use of such rebates will not:

(I) Increase premiums;

(II) Change the actuarial value of the plan inconsistent with federal and state requirements; or

(III) Otherwise result in an impact that is not in the best interest of consumers.

(4) (a) On or before June 1, 2023, the division shall conduct and complete a study to evaluate how rebates may be applied in the individual market to reduce a covered person's out-of-pocket costs at the point of sale or to reduce out-of-pocket costs in prescription drug tiers, taking into consideration the following factors:

(I) Premium impacts;

(II) Changes in the plan's actuarial value; and

(III) Other potential impacts to consumers.

(b) Regardless of the results of the study, a health insurer shall comply with subsection (3) of this section.

(c) The division may contract with a third party to conduct the study required by this subsection (4). The commissioner is not required to comply with the "Procurement Code", articles 101 to 112 of title 24, for the purposes of this section, but shall ensure a competitive process is used to select a third party to conduct the study.

(5) Each health insurer shall report annually:

(a) In a form and manner determined by the commissioner, data demonstrating that all discounts and rebates received by health insurers are used to reduce costs for policyholders in compliance with this section. The commissioner may use discount and rebate data submitted by health insurers to the all-payer health claims database described in section 25.5-1-204 to the extent such data are available from the all-payer health claims database.

(b) An actuarial certification that attests that:

(I) The health insurer and PBM are in compliance with subsections (2) and (3) of this section; and

(II) The data reported as required by this section are accurate.

(6) The division may use data from the department of health care policy and financing, the all-payer health claims database described in section 25.5-1-204, and other sources to verify that a health insurer and PBM are in compliance with this section.

(7) Information submitted by the health insurers and PBMs to the division in accordance with this section is subject to public inspection only to the extent allowed under the "Colorado Open Records Act", part 2 of article 72 of title 24, and in no case shall trade-secret, confidential, or proprietary information be disclosed to any person who is not otherwise authorized to access such information.

(8) This section does not prohibit a health insurer from decreasing cost-sharing amounts or premiums by an amount greater than the amount required in subsection (2) or (3) of this section.

(9) The requirements of subsections (2), (3), and (5) of this section apply to a self-funded health benefit plan and its plan members only if the entity that provides the plan elects to be subject to subsections (2), (3), and (5) of this section for its members in Colorado.

(10) The commissioner shall promulgate rules to implement and enforce this section.

Source: L. 2022: Entire section added, (HB 22-1370), ch. 184, p. 1234, § 6, effective August 10.

10-16-157. Alternative payment model parameters - parameters to include an aligned quality measure set - primary care providers - requirement for carriers to submit alternative payment models to the division - legislative declaration - report - rules - definitions. (1) **Legislative declaration.** The general assembly hereby finds and declares that:

(a) Fee-for-service health-care payment models have long been criticized for incentivizing a higher volume of health-care services rather than a greater value, perpetuating health disparities by failing to meet the needs of patients with the highest barriers to care;

(b) Underinvestment in primary care has created barriers to access that have deterred patients from seeking timely preventive care and made it more difficult for providers to expand team-based, comprehensive care models that improve health outcomes and reduce downstream costs;

(c) Numerous efforts have been made to move our health-care system from a fee-for-service model to a value-based payment model, including comprehensive primary care plus, patient-centered medical homes, the state innovation model, the multi-payer collaborative, the health-care payment learning and action network, and the primary care payment reform collaborative;

(d) Value-based payment models also have not always recognized the unique nature of pediatrics, which requires approaches that reflect specific needs in pediatric populations;

(e) Colorado is part of the center for medicare and medicaid innovation's state transformation collaborative project, which creates an opportunity for alignment between medicare, medicaid, and commercial insurance plans;

(f) By establishing aligned parameters for primary care alternative payment models, including quality metrics and prospective payments, it is the intent of the general assembly to:

(I) Improve health-care quality and outcomes in a manner that reduces health disparities and actively advances health equity;

(II) Increase the number of Coloradans who receive the right care in the right place at the right time at an affordable cost;

(III) Encourage more primary care practices to participate in alternative payment models; provide consistent expectations; reduce administrative burdens; and help small, rural, and independent practices stay independent;

(IV) Support collaboration between physical and behavioral health-care services and local public health agencies and human services departments to improve population health; and

(V) Facilitate practice transformation toward integrated, whole-person care, so practices can coordinate care and address social determinants of health such as housing stability, social support, and food insecurity.

(2) As used in this section:

(a) "Aligned quality measure set" means any set of nationally recognized, evidence-based quality measures developed for primary care provider contracts that incorporate quality measures into the payment terms.

(b) "Alternative payment model" means a health-care payment method that uses financial incentives, including shared-risk payments, population-based payments, and other payment mechanisms, to reward providers for delivering high-quality and high-value care.

(c) "Primary care" or "primary care services" means the provision of integrated, equitable, and accessible health-care services by clinicians who are accountable for addressing a large majority of personal health-care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

(d) "Primary care payment reform collaborative" means the primary care payment reform collaborative convened pursuant to section 10-16-150.

(e) "Primary care provider" or "provider" means the following providers, when the provider is practicing general primary care in an outpatient setting:

(I) Family medicine physicians;

(II) General pediatric physicians and adolescent medicine physicians;

(III) Geriatric medicine physicians;

(IV) Internal medicine physicians, excluding internists who specialize in areas such as cardiology, oncology, and other common internal medicine specialties beyond the scope of general primary care;

(V) Obstetrics and gynecology physicians;

(VI) Advanced practice registered nurses and physician assistants;

(VII) Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting; and

(VIII) Other provider types specified by the commissioner by rule.

(f) "Prospective payment" means a payment made in advance of services that is determined using a methodology intended to facilitate care delivery transformation by paying providers according to a formula based on an attributed patient population to provide predictable revenue and flexibility to manage care within a budget to optimize patient outcomes and better manage population health.

(g) "Risk adjustment" means an adjustment to the payment for primary care services that is determined by quantifying a patient's complexity based on observable data, addressing the time and effort primary care providers spend in caring for patients of different anticipated health

needs, and including social factors such as housing instability, behavioral health issues, disability, and neighborhood-level stressors.

(3) (a) (I) The division shall develop alternative payment model parameters by rule for primary care services offered through health benefit plans.

(II) The division shall develop the primary care alternative payment model parameters in partnership with the department of health care policy and financing, the department of personnel, the department of public health and environment, the primary care payment reform collaborative, and carriers and providers participating in alternative payment models in order to optimize and create positive incentives for alignment between health benefit plans offered by carriers and public payers and achieve the following objectives:

(A) Increased access to high-quality primary care services;

(B) Improved health outcomes and reduced health disparities;

(C) Improved patient and family engagement and satisfaction;

(D) Increased provider satisfaction and retention; and

(E) Increased primary care investment that results in increased health-care value.

(III) At a minimum, the alternative payment model parameters must:

(A) Include transparent risk adjustment parameters that ensure that primary care providers are not penalized for or disincentivized from accepting vulnerable, high-risk patients and are rewarded for caring for patients with more severe or complex health conditions and patients who have inadequate access to affordable housing, healthy food, or other social determinants of health;

(B) Utilize patient attribution methodologies that are transparent and reattribute patients on a regular basis, which must ensure that population-based payments are made to a patient's primary care provider rather than other providers who may only offer sporadic primary care services to the patient and include a process for correcting misattribution that minimizes the administrative burden on providers and patients;

(C) Include a set of core competencies around whole-person care delivery that primary care providers should incorporate in practice transformation efforts to take full advantage of various types of alternative payment models; and

(D) Require an aligned quality measure set that considers the quality measures and the types of quality reporting that carriers and providers are engaging in under current state and federal law and includes quality measures that are patient-centered and patient-informed and address: Pediatric, perinatal, and other critical populations; the prevention, treatment, and management of chronic diseases; and the screening for and treatment of behavioral health conditions.

(IV) The division shall annually consider the recommendations on the alternative payment model parameters and positive carrier incentive arrangements provided by the primary care payment reform collaborative and by carriers and providers participating in alternative payment models but not participating in the primary care payment reform collaborative.

(V) The alternative payment models must also:

(A) Ensure that any risk or shared savings arrangements minimize significant financial risk for providers when patient costs exceed what can be predicted;

(B) Incentivize the integration of behavioral health-care services through local partnerships or the hiring of in-house behavioral health staff;

(C) Include prospective payments to providers for health promotion, care coordination, health navigation, care management, patient education, and other services designed to prevent and manage chronic conditions and address social determinants of health;

(D) Recognize the various levels of advancement of alternative payment models and preserve options for carriers and providers to negotiate models suited to the competencies of each individual primary care practice; and

(E) Support evidence-based models of integrated care that focus on measurable patient outcomes.

(b) (I) Except as provided in subsection (3)(b)(II) of this section, for health benefit plans that are issued or renewed on or after January 1, 2025, a carrier shall ensure that any alternative payment models for primary care incorporate the parameters established in this subsection (3).

(II) For managed care plans that are issued or renewed on or after January 1, 2025, and in which services are primarily offered through one medical group contracted with a nonprofit health maintenance organization, a carrier shall ensure that any alternative payment models for primary care incorporate the aligned quality measure set established in subsection (3)(a)(III)(D) of this section.

(c) By December 1, 2023, the commissioner shall promulgate rules detailing the requirements for alternative payment model parameters alignment. The division shall allow carriers the flexibility to determine which network providers and products are best suited to achieve the goals and incentives set by the division in this section.

(4) Once the division has five years of data, the division shall analyze the data and, subject to available appropriations, produce a report on the data that aggregates data across all carriers. The division shall present the findings to the general assembly during the department of regulatory agencies' presentation to legislative committees at hearings held pursuant to the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2.

(5) The division shall retain a third-party contractor to design an evaluation plan for the implementation of primary care alternative payment models by carriers. The plan must include alternative payment models implemented by carriers and providers prior to January 1, 2025. In designing the evaluation plan, the contractor shall, to the extent practicable:

(a) Report on the effects of the alternative payment models on populations that have historically faced systemic barriers to health access;

(b) Report on the effects of the alternative payment models on primary care providers, primary care practices, and primary care practices' ability to stay independent, including the effects on primary care providers' administrative burdens; and

(c) Consider and identify any available data sources or data limitations that should be included or addressed in the evaluation plan to allow for measurement and reporting on the effects of the primary care payment model parameters on such populations, including the collection or analysis of data that is disaggregated, at a minimum, by race, ethnicity, sex, gender, and age.

(6) To support the implementation of aligned primary care alternative payment model parameters by carriers, the division shall retain a third-party contractor to provide technical assistance to carriers. The division shall work with carriers to determine the nature and scope of the technical assistance and other supports that will best facilitate the implementation of aligned primary care alternative payment model parameters.

(7) The commissioner may promulgate rules necessary to implement this section.

(8) Any information submitted to the division in accordance with this section is subject to public inspection only to the extent allowed under the "Colorado Open Records Act", part 2 of article 72 of title 24. The division shall not disclose any trade secret or confidential or proprietary information to any person who is not otherwise authorized to access the information, including any confidential or proprietary contractual information between carriers and providers.

Source: L. 2022: Entire section added, (HB 22-1325), ch. 181, p. 1203, § 1, effective August 10.

10-16-158. Treatment of sexually transmitted infection - cost sharing - rules - definition. (1) For health benefit plans issued or renewed on or after January 1, 2025, if the treatment of a sexually transmitted infection, as defined in section 25-4-402 (10), is a covered service, the health benefit plan must provide the coverage without deductibles, copayments, coinsurance, annual or lifetime maximum benefit limits, or other cost sharing for or limits on the coverage for the treatment of a sexually transmitted infection.

(2) The provisions of this section do not apply to a high deductible health benefit plan pursuant to 26 U.S.C. sec. 223, as amended, issued or renewed in this state until an eligible insured's deductible has been met, unless allowed pursuant to federal law.

(3) The commissioner may promulgate rules to implement this section.

(4) As used in this section, "treatment" means medically necessary care for the management of the existing sexually transmitted infection.

Source: L. 2023: Entire section added, (SB 23-189), ch. 69, p. 257, § 4, effective April 14.

Editor's note: This section is similar to former § 12-170-109 (7) as it existed prior to 2023.

10-16-159. Coverage for sterilization services - cost sharing. (1) For health benefit plans issued or renewed on or after January 1, 2025, if sterilization services are a covered service, the health benefit plan must provide the coverage regardless of the covered person's sex or gender and without deductibles, copayments, coinsurance, annual or lifetime maximum benefit limits, or other cost sharing for or limits on the coverage for sterilization services.

(2) The provisions of this section do not apply to a high deductible health benefit plan pursuant to 26 U.S.C. sec. 223, as amended, issued or renewed in this state until an eligible insured's deductible has been met, unless allowed pursuant to federal law.

Source: L. 2023: Entire section added, (SB 23-189), ch. 69, p. 258, § 4, effective April 14.

10-16-160. Cost sharing - prescription epinephrine - limits - rules - definition. (1) As used in this section, unless the context otherwise requires, "epinephrine auto-injector" has the same meaning as set forth in section 12-280-142 (1)(c).

(2) For health coverage plans issued or renewed on or after January 1, 2024, if a carrier provides coverage for prescription epinephrine auto-injectors, the carrier shall cap the total amount that a covered person is required to pay for all covered prescription epinephrine auto-injectors at an amount not to exceed sixty dollars for a two-pack of epinephrine auto-injectors, regardless of the amount or type of epinephrine needed to fill the covered person's prescription.

(3) Nothing in this section prevents a carrier from reducing a covered person's cost sharing to an amount that is lower than the amount specified in subsection (2) of this section.

(4) The coverage required by this section may be offered through a high deductible plan that includes a health savings account pursuant to 26 U.S.C. sec. 223 of the federal "Internal Revenue Code of 1986"; except that a carrier may apply deductible amounts for the required coverage if the coverage is not considered by the United States department of the treasury to be preventive or to have an acceptable deductible amount.

(5) The commissioner may use any of the commissioner's enforcement powers to obtain a carrier's compliance with this section.

(6) The commissioner may promulgate rules as necessary to implement and administer this section and to align with federal requirements.

Source: L. 2023: Entire section added, (HB 23-1002), ch. 447, p. 2631, § 2, effective August 7.

Cross references: For the legislative declaration in HB 23-1002, see section 1 of chapter 447, Session Laws of Colorado 2023.

10-16-161. Calculation of contribution to out-of-pocket and cost-sharing requirements - exception - definition - rules. (1) (a) When calculating a covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement under the covered person's health benefit plan, a carrier or PBM shall include any amount paid by the covered person or by another person on behalf of the covered person for a prescription drug if:

(I) The prescription drug does not have a generic equivalent or, for a prescription drug that is a biological product, the prescription drug does not have a biosimilar drug, as defined in 42 U.S.C. sec. 262 (i)(2), or an interchangeable biological product, as defined in 42 U.S.C. sec. 262 (i)(3); or

(II) The prescription drug has a generic equivalent, a biosimilar drug, or an interchangeable biological product, and the covered person is using the brand-name prescription drug after:

(A) Obtaining prior authorization from the carrier or pharmacy benefit manager;

(B) Complying with a step-therapy protocol required by the carrier or pharmacy benefit manager; or

(C) Receiving approval from the carrier or pharmacy benefit manager through the carrier's or pharmacy benefit manager's exceptions, appeal, or review process.

(b) A covered person is not required to comply with the utilization management processes described in subsection (1)(a)(II) of this section, including prior authorization and step-therapy protocol requirements, when those processes are prohibited under this article 16 or other applicable state law.

(2) If application of subsection (1) of this section would make a covered person's health savings account contributions ineligible under section 223 of the federal "Internal Revenue Code of 1986", 26 U.S.C. sec. 223, as amended, subsection (1) of this section applies to the deductible applicable to the covered person's health benefit plan after the covered person has satisfied the minimum deductible amount under 26 U.S.C. sec. 223; except that, with respect to items or services that are preventive care pursuant to 26 U.S.C. sec. 223 (c)(2)(C), subsection (1) of this section applies, regardless of whether the minimum deductible under 26 U.S.C. sec. 223 has been satisfied.

(3) The commissioner may adopt rules as necessary to implement this section.

(4) As used in this section, "cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost sharing, including a limitation subject to 42 U.S.C. sec. 18022 (c) or 42 U.S.C. sec. 300gg-6 (b), required by or on behalf of a covered person in order to receive a prescription drug covered by the covered person's health benefit plan, whether covered as a medical or pharmacy benefit.

Source: L. 2023: Entire section added, (SB 23-195), ch. 351, p. 2105, § 2, effective August 7.

Editor's note: Section 3(2) of chapter 351 (SB 23-195), Session Laws of Colorado 2023, provides that the act adding this section applies to health benefit plans issued or renewed on or after January 1, 2025.

Cross references: For the legislative declaration in SB 23-195, see section 1 of chapter 351, Session Laws of Colorado 2023.

10-16-162. Prohibition on discrimination for coverage based solely on natural medicine consumption - definitions. (1) A carrier that offers, issues, or renews a health benefit plan shall not, solely on the basis of a person's consumption of natural medicine or natural medicine product:

(a) Decline or limit coverage of a person; or

(b) Penalize a covered person or reduce or limit coverage for a person.

(2) A carrier that offers, issues, or renews a health benefit plan that provides coverage for anatomical gifts, organ transplants, or related treatments or services shall not, solely on the basis of a covered person's consumption of natural medicine or natural medicine product:

(a) Deny coverage to a covered person for an organ transplant or related treatment or services;

(b) Decline or limit coverage of a covered person solely for the purpose of avoiding the requirements of this section; or

(c) Penalize a covered person or reduce or limit coverage for a covered person for health-care services related to organ transplantation, as determined in consultation with the attending physician and the covered person or the covered person's representative.

(3) This section does not require a health benefit plan to provide coverage for the donation of an anatomical gift, an organ transplant, or related treatment or services.

(4) As used in this section, unless the context otherwise requires:

(a) "Anatomical gift" means the donation of part of a human body for the purpose of transplantation to another person.

(b) (I) "Natural medicine" means the following substances:

(A) Dimethyltryptamine;

(B) Mescaline;

(C) Ibogaine;

(D) Psilocybin; or

(E) Psilocin.

(II) "Natural medicine" does not mean a synthetic or synthetic analog of the substances listed in this subsection (4)(b), including a derivative of a naturally occurring compound of natural medicine that is produced using chemical synthesis, chemical modification, or chemical conversion.

(c) "Natural medicine product" means a product infused with natural medicine that is intended for consumption.

Source: L. 2023: Entire section added, (SB 23-290), ch. 249, p. 1418, § 32, effective July 1. **L. 2024:** (4)(b)(I)(E) amended, (SB 24-198), ch. 452, p. 3138, § 1, effective June 6.

10-16-163. Contracts - health benefit plans - pharmacy benefit managers - policyholders - transparency requirements - rules - definitions. (1) For a contract between a carrier or pharmacy benefit manager and a certificate holder or policyholder that is issued or renewed on or after January 1, 2025, the amount charged by the carrier or PBM to the certificate holder or policyholder for a prescription drug dispensed to a covered person must be equal to or less than the amount paid by the carrier or PBM to a contracted pharmacy for such prescription drug dispensed to such covered person residing in Colorado.

(2) (a) For group health benefit plans in effect during calendar year 2025 and each calendar year thereafter, a carrier or pharmacy benefit manager shall disclose to each policyholder or the policyholder's specifically designated broker or consultant the prescription drug contract terms required by this subsection (2). For group health benefit plans in effect during calendar year 2023 or 2024 or both, the disclosure must also include any changes in terms between each calendar year.

(b) The disclosures required pursuant to this subsection (2) must include:

(I) The ingredient cost average reimbursement rate for:

(A) Generic drugs dispensed at retail pharmacies;

(B) Brand-name drugs dispensed at retail pharmacies;

(C) Specialty drugs dispensed at retail pharmacies;

(D) Generic drugs dispensed at mail-order pharmacies;

(E) Brand-name drugs dispensed at mail-order pharmacies;

(F) Specialty drugs dispensed at mail-order pharmacies; and

(G) Specialty drugs dispensed at any specialty pharmacy, including a pharmacy that is fully or partially owned by a contracting PBM, a carrier, or the PBM's or carrier's holding companies or affiliates;

(II) The average dispensing fee paid to each type of pharmacy, including each retail, mail-order, and specialty pharmacy;

(III) The charge per prior authorization;

(IV) Utilization management programs and associated fees;

(V) Any other contracted services and associated fees;

(VI) The average rebate across all paid prescriptions for the respective group health benefit plan and the average rebate across all paid prescriptions that pay a rebate for the respective group health benefit plan; and

(VII) The rebate guarantee, where applicable.

(c) For contracts between a carrier or pharmacy benefit manager and a certificate holder or policyholder that are renewed in calendar year 2025 and each calendar year thereafter, the carrier or PBM shall calculate and communicate to the certificate holder or policyholder the value of the difference between the contract terms in the renewed contracts and the contracts that were in effect the previous calendar year, annualizing the previous year's actual data for each respective certificate holder or policyholder. The value communicated shall include annual aggregate savings, annual aggregate savings per employee per year, and annual aggregate savings per covered person per year.

(d) A carrier or pharmacy benefit manager shall provide to each certificate holder or policyholder, for voluntary consideration, options to repurpose aggregate savings in the form of reductions to out-of-pocket costs such as deductibles, copayment amounts, coinsurance, or premium contributions. The carrier or PBM shall provide the information to certificate holders or policyholders no less than ninety days before the date of the contract renewal.

(e) A carrier or PBM shall provide the information specified in subsections (2)(b), (2)(c), and (2)(d) of this section to all certificate holders and policyholders for contracts in effect during calendar year 2025, including certificate holders and policyholders that may not receive a renewal notice due to a multiyear contractual agreement or for any other reason except notice of termination.

(f) The disclosures required in subsections (2)(b)(VI) and (2)(b)(VII) of this section must not disclose any proprietary rebate information between a drug manufacturer and the pharmacy benefit manager or its carrier affiliate. The disclosure of data required by these subsections must represent the aggregate value of rebates passing through from the pharmacy benefit manager or its carrier affiliate to the health benefit plan as defined by rule of the commissioner.

(g) A carrier may exempt a segment of its business from this subsection (2). The carrier's exempted business segment must provide the majority of covered medical professional services through a single, contracted medical group and operate its own pharmacies through which at least eighty-five percent of its aggregate prescription drug claims are filled. On and after August 7, 2023, a carrier that meets the exemption criteria in this subsection (2)(g) shall submit an attestation to the division of such compliance with each rate filing required pursuant to section 10-16-107. The carrier or PBM shall disclose all data requirements as outlined in this subsection (2) to the carrier's group policyholders that are primarily accessing prescription drug benefits through a third-party PBM contracted with the carrier.

(3) The commissioner shall promulgate rules to implement this section.

(4) (a) The commissioner may conduct an audit or market conduct examination of a carrier or pharmacy benefit manager to ensure compliance with this section. The commissioner, pursuant to any rules promulgated by the division, may audit a carrier or PBM annually to determine if there is a violation of this section.

(b) The commissioner may determine a carrier's or PBM's compliance with this section based on a sampling of data or based on a full claims audit. The sampling of data and any

extrapolation from the data used to determine penalties must be reasonably valid from a statistical standpoint and in accordance with generally accepted auditing standards. A carrier or PBM that does not comply with a division request for the data required to complete an audit violates this section and may be subject to penalties.

(c) Information obtained through an audit conducted pursuant to this subsection (4) is proprietary and confidential information, available only to the commissioner and the commissioner's auditing designee, and is not subject to disclosure unless specifically required by state or federal law.

(5) The failure of a carrier or PBM to comply with this section is an unfair method of competition and an unfair or a deceptive act or practice in the business of insurance pursuant to section 10-3-1104 (1).

(6) (a) The requirements of subsections (1), (2), and (4) of this section apply to an employer-sponsored health benefit plan, an associated pharmacy benefit manager, and the health benefit plan members only if a person, Taft-Hartley trust, municipality, state, labor union, plan sponsor, or employer that provides the employer-sponsored health benefit plan elects to be subject to subsections (1), (2), and (4) of this section for its members that reside in Colorado.

(b) As used in this subsection (6), "pharmacy benefit manager" means an entity doing business in this state that administers or manages prescription drug benefits, including claims processing services and other prescription drug or device services as defined in section 10-16-122.1, that is in a contractual relationship directly or indirectly through an affiliate with an employer-sponsored health benefit plan, which includes plans that are self-insured or regulated by the federal "Employee Retirement Income Security Act of 1974", 29 U.S.C. sec. 1001 et seq., as amended, offered by:

(I) A person;

(II) A Taft-Hartley trust;

(III) A municipality;

(IV) The state;

(V) A labor union;

(VI) A plan sponsor;

(VII) An employer; or

(VIII) A coalition of employers or aggregation of employers working together to negotiate improved contract terms with a pharmacy benefit manager.

(7) As used in this section, unless the context otherwise requires:

(a) "Contracted pharmacy" means a pharmacy that has contracted with a carrier, a pharmacy benefit manager, or an affiliate of the carrier or PBM.

(b) "Ingredient cost" means the actual amount paid to a pharmacy by a pharmacy benefit manager for a prescription drug, not including a dispensing fee or patient cost-sharing amount.

(c) "Pharmacy" means an entity where medicinal drugs are dispensed and sold, including a retail pharmacy, mail-order pharmacy, specialty pharmacy, hospital outpatient setting, or other related pharmacy.

Source: L. 2023: Entire section added, (HB 23-1201), ch. 158, p. 684, § 1, effective August 7.

10-16-164. Hospital facility fee report - data collection. The commissioner is authorized to collect from a carrier offering a health benefit plan information specified in section 25.5-4-216, if available, for purposes of facilitating the development of the report relating to facility fees.

Source: L. 2023: Entire section added, (HB 23-1215), ch. 277, p. 1635, § 2, effective May 30.

10-16-165. Dental coverage plans - dental loss ratio - rules - definitions. (1) As used in this section, unless the context otherwise requires:

(a) "Community benefit expenditure" means an expenditure for an activity or program, or to an organization that seeks to achieve the objectives of improving access to dental services and enhancing dental public health. This includes an activity that:

(I) Is available broadly to the public and serves low-income consumers;

(II) Reduces geographic, financial, or cultural barriers to accessing dental services, and, if the activity ceased to exist, would result in access problems;

(III) Addresses oral health workforce shortages, such as advancing education and training of oral health professionals; or

(IV) Leverages or enhances dental public health activities.

(b) "Dental coverage plan" means a health coverage plan that includes coverage for the costs of dental care services. "Dental coverage plan" includes a plan issued by a prepaid dental plan organization that has a certificate of authority to operate pursuant to part 5 of this article 16.

(c) (I) "Dental loss ratio" means the percentage of premium dollars collected each year for a dental coverage plan that the dental coverage plan incurs on dental services provided to an enrollee, separate from overhead and administrative costs.

(II) The dental loss ratio is calculated by dividing the numerator by the denominator, where:

(A) The numerator is the sum of the amount incurred for clinical dental services provided to enrollees, the amount incurred on activities that improve dental care quality, and the amount of claims payments identified through fraud reduction efforts; and

(B) The denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community benefit expenditures, and any other payments required by federal law.

(2) (a) The commissioner shall define by rule:

(I) Expenditures for clinical dental services;

(II) Activities that improve dental care quality;

(III) Overhead and administrative cost expenditures; and

(IV) Nonprofit community benefit expenditures that are aligned with exclusion parameters and limits outlined in 45 CFR 158.162; except that the commissioner shall ensure that only expenditures that improve access to dental services or enhance dental health, and no overhead or administrative costs, are reported under this section.

(b) The definitions promulgated by rule pursuant to this section must be consistent with similar definitions that are used for the reporting of medical loss ratios by carriers offering health benefit plans in the state. Overhead and administrative costs must not be included in the numerator as described in subsection (1)(c)(II)(A) of this section.

(3) (a) On or before July 31, 2024, and on or before July 31 each year thereafter, a carrier that issues, sells, renews, or offers a dental coverage plan shall file a dental loss ratio form electronically with the division for the preceding calendar year in which dental coverage was provided by the dental coverage plan. The commissioner may create a new reporting form or use an existing reporting form to facilitate data collection. The commissioner shall ensure that fields are reported consistently by carriers. The filing must:

(I) Report the calculated dental loss ratio according to the formula in subsection (1)(c)(II) of this section;

(II) Separately report each data element described in subsection (1)(c) of this section;

(III) Report additional data that includes the number of enrollees, the plan cost-sharing and deductible amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit;

(IV) Report data by market segment and product type, as defined by rule of the commissioner; and

(V) Be in a form and manner as prescribed by rule of the commissioner.

(b) For the report to be submitted on or before July 31, 2024, a carrier shall also submit the information required in subsection (3)(a) of this section for the plan years 2021 through 2024.

(c) If the commissioner deems that data verification of a carrier's dental loss ratio for a dental coverage plan is necessary, the commissioner shall give the carrier at least thirty days' notification prior to beginning the verification process with the carrier.

(d) (I) By January 1 of the year after the division receives the dental loss ratio information collected pursuant to subsection (3)(a) of this section, the division shall make the information, including the aggregate dental loss ratio and the data reported pursuant to subsections (3)(a)(II) and (3)(a)(III) of this section, available to the public in a searchable format on a public website that allows members of the public to compare dental loss ratios among carriers by plan type by:

(A) Posting the information on the division's website; or

(B) Providing the information to the administrator of the all-payer health claims database established pursuant to section 25.5-1-204. If the division provides the information to the administrator, the administrator shall make the information available to the public in a format determined by the division.

(II) The division shall report the data in subsection (3)(a) of this section and, if available, subsection (4)(a) of this section to the general assembly during the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearings held pursuant to part 2 of article 7 of title 2.

(4) (a) Once the division has collected the data pursuant to subsection (3) of this section for two calendar years, the commissioner shall promulgate rules that create a process to identify any carriers that significantly deviate from average dental loss ratios and to investigate the causes of the deviation. Such process shall include:

(I) Calculating an average dental loss ratio for each market segment using aggregate data for a three-year period, consisting of data for the dental loss ratio reporting year that is being reported and the data for the two prior dental loss ratio reporting years;

(II) Identifying as outliers the dental coverage plans that fall outside of a set number of standard deviations from the average dental loss ratio, as determined by rule of the commissioner

based on review of the data and consideration of the impact of nonprofit community benefit expenditures on any outlier calculation.

(b) The commissioner may apply more restrictive standard deviation metrics over time to prevent declines in the average dental loss ratio in a market segment and may establish by rule additional criteria for use in identifying outliers.

(5) (a) The commissioner may enforce compliance with the reporting requirements in this section and impose a penalty or remedy against a person who violates this section.

(b) The commissioner may investigate or take enforcement actions against carriers that are determined to be outliers pursuant to subsection (4) of this section and rules adopted pursuant to said subsection (4) and impose a penalty or remedy against a person who violates this section.

(6) The commissioner may promulgate rules to implement this section.

Source: L. 2023: Entire section added, (SB 23-179), ch. 332, p. 1990, § 3, effective August 7.

Cross references: For the legislative declaration in SB 23-179, see section 1 of chapter 332, Session Laws of Colorado 2023.

10-16-166. Prohibition on using the body mass index or ideal body weight - medical necessity criteria - rules. (1) (a) Every health benefit plan subject to part 2, 3, or 4 of this article 16, except those described in section 10-16-102 (32)(b), shall not utilize the body mass index, ideal body weight, or any other standard requiring an achieved weight when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder, including but not limited to bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(b) Subsection (1)(a) of this section does not apply when determining medical necessity or the appropriate level of care for an individual diagnosed with anorexia nervosa, restricting subtype, or binge-eating/purging subtype; however, body mass index, ideal body weight, or any other standard requiring an achieved body weight must not be the determining factor when assessing medical necessity or the appropriate level of care for an individual diagnosed with anorexia nervosa, restricting subtype, or binge-eating/purging subtype.

(2) The following factors, at a minimum, must be considered when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder:

(a) The individual's eating behaviors;

(b) The individual's need for supervised meals and support interventions;

(c) Laboratory results, including, but not limited to, the individual's heart rate, renal or cardiovascular activity, and blood pressure;

(d) The recovery environment; and

(e) Co-occurring disorders the individual may have.

(3) The commissioner may promulgate rules as necessary to implement and enforce this section.

Source: L. 2023: Entire section added, (SB 23-176), ch. 275, p. 1625, § 1, effective January 1, 2024.

10-16-167. Medical aid-in-dying - carrier prohibitions. (1) A carrier shall not:

(a) Deny or alter benefits otherwise available to a covered individual with a terminal disease based on the availability of medical aid-in-dying pursuant to article 48 of title 25.

(b) Attempt to coerce an individual with a terminal disease to make a request for medical aid-in-dying medication.

Source: L. 2024: Entire section added, (SB 24-068), ch. 406, p. 2799, § 20, effective August 7.

10-16-168. Carriers - health care - price transparency - rules - legislative declaration - definitions. (1) **Legislative declaration.** (a) The general assembly finds and declares that:

(I) The federal "Patient Protection and Affordable Care Act", Pub.L. 111-148, was enacted on March 23, 2010, and the federal "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152, was enacted on March 30, 2010, and these acts are referred to collectively as "PPACA";

(II) PPACA reorganized, amended, and added to the provisions of part A of Title XXVII of the federal "Public Health Service Act", Pub.L. 78-410, relating to health coverage requirements for group health plans and health insurance issuers in the group and individual markets;

(III) Section 2715A of the federal "Public Health Service Act", Pub.L. 78-410, provides that group health plans and health insurance issuers offering group or individual health insurance coverage must comply with section 1311 (e)(3) of PPACA, which addresses transparency in health coverage and imposes certain reporting and disclosure requirements for health plans;

(IV) Effective January 11, 2021, the federal centers for medicare and medicaid services, or "CMS", published the final rule to implement PPACA, codified at 45 CFR 147.210 to 147.212;

(V) In its summary of the final rule, CMS states that requiring plans to disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates for prescription drugs "can help ensure the accurate and timely disclosure of information appropriate to support an efficient and competitive health care market"; and

(VI) As former United States President Donald Trump's "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First" explains: "To make fully informed decisions about their healthcare, patients must know the price and quality of a good or service in advance." Additionally, the executive order then notes that "patients often lack both access to useful price and quality information and the incentives to find low-cost, high-quality care." The lack of this information is widely understood to be one of the root problems causing dysfunction within the United States' health-care system.

(b) Therefore, in order to protect Colorado health-care consumers, it is the intent of the general assembly to require carriers to provide consumer access to accurate and accessible health-care coverage price information.

(2) **Definitions.** As used in this section:

(a) "Carrier price transparency laws" means the requirements codified in 42 U.S.C. sec. 18031 (e)(3), as amended, and the implementing rules adopted by the United States department of health and human services.

(b) "Federal centers for medicare and medicaid services" or "CMS" means the centers for medicare and medicaid services in the United States department of health and human services.

(c) "Items and services" or "items or services" means "items or services" as defined in 45 CFR 147.210 (a)(2)(xiii).

(d) "Pharmacy benefit and drug cost reporting laws" means the requirements codified in 26 U.S.C. sec. 9825, as amended.

(3) **Transparency - rules.** (a) Beginning July 1, 2024, a carrier shall comply with carrier price transparency laws, including making available an internet-based self-service tool that provides real-time responses to each individual enrolled in a health benefit plan who requests cost-sharing information.

(b) The commissioner may adopt rules to implement this subsection (3) that align, to the extent practicable, with the carrier price transparency laws and any subsequent guidance from the federal centers for medicare and medicaid services.

(4) **Price-transparency files - rules.** (a) Each carrier shall make publicly available, in a form and manner determined by the commissioner, three price-transparency files. The files must include information regarding:

(I) Beginning July 1, 2025, and every six months thereafter, negotiated rates for all covered items and services between the health benefit plan or carrier and in-network providers;

(II) Beginning July 1, 2025, and every six months thereafter, unique out-of-network allowed amounts and billed charges for covered items and services furnished by out-of-network providers; and

(III) No earlier than twelve months after the date of the finalization of requirements and technical specifications by the United States secretary of labor, the United States secretary of health and human services, and the United States secretary of the treasury, in-network negotiated rates and historical net prices for all prescription drugs covered by the health benefit plan or carrier.

(b) Information submitted by health insurers and pharmacy benefit managers to the division in accordance with subsection (4)(a) of this section is subject to public inspection under the "Colorado Open Records Act", part 2 of article 72 of title 24.

(c) On or before January 1, 2025, the commissioner shall conduct a stakeholder engagement process that includes representatives from carriers regulated in this state that are required to produce the price-transparency files to create a standardized template, including the format and method of submission, for the price-transparency files. The standardized template must not require data that is in addition to what is required by the United States secretary of labor, the United States secretary of health and human services, and the United States secretary of the treasury. The data and format of the submission shall not be materially different from the data that carriers are required to submit under the federal carrier price transparency laws. Submission of Colorado-specific data shall not be considered a material difference.

(d) The commissioner shall promulgate rules to implement this subsection (4).

(e) Each carrier shall update the price-transparency files and information required by subsection (4)(a) of this section at least every six months. Each carrier shall clearly indicate the date that the files were most recently updated.

Source: L. 2024: Entire section added, (SB 24-080), ch. 411, p. 2837, § 1, effective June 5.

10-16-169. Carriers - prescription drug coverage - transparency. Beginning July 1, 2025, and on or before each July 1 thereafter, each carrier shall submit to the commissioner, in the same form and manner as submitted to the United States secretary of health and human services, information required by federal pharmacy benefit and drug cost reporting laws.

Source: L. 2024: Entire section added, (SB 24-080), ch. 411, p. 2840, § 1, effective June 5.

10-16-170. Delivery of notices and documents by electronic means - definitions - consent required - withdrawal of consent - employers - immunity from liability - posting of plans and endorsements on carrier website - applicability - rules. [*Editor's note: This section is effective January 1, 2026.*]

(1) As used in this section, unless the context otherwise requires:

(a) "Delivered by electronic means" means:

(I) Delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(II) Posting on an electronic network, site, or consumer portal accessible via the internet, a mobile application, a computer, a mobile device, a tablet, or any other electronic device, together with separate notice of the posting provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party. The separate notice of the posting must contain the internet address at which the documents are posted, and delivery is effective upon the posting or the actual delivery of the separate notice of the posting, whichever occurs later.

(b) "Party" means a recipient of a notice or document required as part of an insurance transaction, including an applicant for health insurance coverage, a covered person, a policyholder, or an annuity contract holder.

(2) (a) Notwithstanding any provision of this article 16 to the contrary, subject to the requirements of this section, a notice to or from a party or other document required by law in an insurance transaction that is related to a provision in a health insurance contract or that is to serve as evidence of health insurance coverage may be delivered by a carrier or to a carrier, stored, and presented by electronic means if the electronic means meet the requirements of the "Uniform Electronic Transactions Act", article 71.3 of title 24.

(b) The delivery of a notice or document in accordance with this section is considered the equivalent to and has the same effect as any delivery method required by law, including delivery by first-class mail, first-class mail with postage prepaid, certified mail, certificate of mail, or certificate of mailing.

(c) A carrier shall establish a consumer portal or other accessible means for policyholders to submit requests, notices, or responses to the carrier by electronic means,

including the ability to confirm that the communication by electronic means has been received by the carrier.

(d) A carrier shall not require policyholders to submit requests, notices, or responses by facsimile or nonelectronic means, unless the consumer chooses submission by facsimile or nonelectronic means.

(3) A notice or document may be delivered by electronic means by a carrier to a party pursuant to this section if:

(a) The party has affirmatively consented electronically, or confirmed consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means to which the party has given consent, and the party has not withdrawn the consent; and

(b) Before the party consents, the carrier provides the party a clear and conspicuous statement informing the party of:

(I) The hardware and software requirements for access to and retention of a notice or document delivered by electronic means;

(II) The types of notices and documents to which the party's consent applies;

(III) The right of the party to withdraw consent at any time, at no charge, and any conditions or consequences to be imposed in the event consent is withdrawn;

(IV) The procedures a party must follow to withdraw consent, which procedures must be no more burdensome than the procedures required to provide consent, to have a notice or document delivered by electronic means, or to update the party's electronic mail address; and

(V) The party's right to have any notice or document delivered in paper form upon request.

(4) (a) Notwithstanding subsection (3) of this section, an employer offering a health coverage plan may, on behalf of a covered person enrolled in the plan, provide consent to the mailing of all communications related to the plan by electronic means if, before consenting on behalf of a covered person, an employer has:

(I) Confirmed that the covered person routinely uses electronic communications during the normal course of employment and is able to access and retain electronic communications that may be delivered by the carrier; and

(II) Informed the covered person that the consent will be provided and notices and documents related to the plan may be delivered to the covered person's work electronic mail address unless the covered person affirmatively opts out of delivery by electronic means or provides an alternative electronic mail address.

(b) The carrier for the health coverage plan shall:

(I) Provide the covered person with a clear and conspicuous statement informing the covered person of:

(A) The types of notices and documents that may be delivered to the covered person by electronic means;

(B) The right of the covered person to withdraw consent to have a notice or document delivered by electronic means at any time without charge;

(C) The procedures the covered person must follow to withdraw consent to have a notice or document delivered by electronic means and to update the covered person's electronic mail address;

(D) The right of the covered person to have any notice or document delivered, upon request, in paper form free of charge; and

(E) The right of the covered person to submit requests, notices, or responses through electronic means or through a consumer portal; and

(II) Provide the covered person an opportunity to opt out of delivery by electronic means.

(5) A carrier that receives a party's consent for the delivery of notices or documents by electronic means shall ensure that the applicable provisions of the conditions under the "Uniform Electronic Transactions Act", article 71.3 of title 24, are satisfied, as required by subsection (2)(a) of this section.

(6) (a) When a notice or document is provided electronically to a party pursuant to this section, a carrier shall apprise the party of the significance of the notice or document, when it is not otherwise reasonably evident, and of the right to request and obtain a paper version of the notice or document.

(b) A carrier shall take all reasonable measures to ensure that delivery by electronic means pursuant to this section results in the party's receipt of the notice or document.

(7) After a party gives consent for the delivery of notices and documents by electronic means, if a change in the hardware or software requirements needed to access or retain a notice or document creates a material risk that the party will not be able to access or retain a notice or document to which the consent applies, the carrier shall not deliver the notice or document by electronic means unless the carrier complies with subsection (3) of this section and provides the party a statement that describes:

(a) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(b) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

(8) (a) This section does not affect requirements related to the content or timing of any notice or document required by any other applicable law.

(b) If another applicable law expressly requires a confirmation of receipt of a notice or document, the notice or document may be delivered by electronic means only if the method used provides for active confirmation of receipt by the recipient.

(c) This section does not apply to a notice or document that a carrier delivered by electronic means before the effective date of this section to a party who, before that date, consented to receive the notice or document by electronic means as otherwise allowed by law.

(d) The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party shall not be denied solely because of the failure of the carrier to obtain or confirm the party's consent for the delivery of notices or documents by electronic means so long as the notice or document is delivered in paper form.

(9) (a) A party's withdrawal of consent does not affect the legal effectiveness, validity, or enforceability of a notice or document that is delivered by electronic means to the party before the party's withdrawal of consent is effective.

(b) A withdrawal of consent by a party shall be effective within a reasonable period of time after receipt of the withdrawal by the carrier.

(c) A carrier's failure to comply with subsection (3) or (4) of this section may be treated, at the election of a party, as a withdrawal of the party's consent for purposes of this section.

(10) If the consent of a party to receive notices or documents by electronic means is on file with a carrier before the effective date of this section, and a carrier intends to deliver additional notices or documents to the party by electronic means pursuant to this section, then prior to delivering the additional notices or documents by electronic means, the carrier shall comply with subsection (2) of this section and shall provide the party a statement that describes:

(a) The notices or documents to be delivered by electronic means that were not previously delivered by electronic means; and

(b) The party's right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

(11) (a) A carrier shall deliver a notice or document by any other delivery method permitted by law other than by electronic means if:

(I) The carrier attempts to deliver the notice or document by electronic means and reasonably believes that the notice or document has not been received by the party; or

(II) The carrier becomes aware that the electronic mail address provided by the party is no longer valid.

(b) A party's consent to have notices or documents delivered by electronic means does not preclude the carrier from delivering a notice or document by any other delivery method permitted by law.

(12) An insurance producer licensed pursuant to part 4 of article 2 of this title 10 is not subject to civil liability for any harm or injury that occurs because of a party's election to receive any notice or document by electronic means or by a carrier's failure to deliver or a party's failure to receive a notice or document by electronic means.

(13) (a) A health coverage plan and an endorsement that does not contain personal identifying information may be mailed, delivered, or, if the carrier obtains separate, specific consent, posted on the carrier's website. If the carrier elects to post a covered person's health coverage plan and an endorsement on the carrier's website in lieu of mailing or delivering the health coverage plan and endorsement to the covered person, the carrier shall comply with the following conditions:

(I) The health coverage plan and endorsement must be accessible to the covered person and producer of record and remain accessible while the health coverage plan is in force;

(II) After the expiration of the health coverage plan, the carrier shall either:

(A) Make the expired health coverage plan and endorsement available upon request, for a period of five years; or

(B) If the carrier continues to make the expired health coverage plan or endorsement available on its website, continue to allow the covered person to access the health coverage plan and endorsement for at least five years;

(III) The carrier shall post the health coverage plan and endorsement in a manner that enables the covered person and producer of record to print and save the health coverage plan and endorsement using a program or application that is widely available on the internet and free to use;

(IV) The carrier shall provide the following information in, or simultaneous with, each declaration page provided at the time of issuance of the initial health coverage plan and any renewals of the health coverage plan:

(A) A description of the exact health coverage plan and endorsement form applicable to the covered person;

(B) A description of the covered person's right to receive, upon request and without charge, an electronic and a paper copy of the health coverage plan and endorsement; and

(C) The internet address at which the health coverage plan and endorsement are posted;

(V) The carrier, upon a covered person's request and without charge following receipt of the initial copy, shall mail a paper copy of the health coverage plan and endorsement to the covered person; except that the carrier may charge a fee for subsequent mailings of paper copies; and

(VI) The carrier shall provide notice, either electronically or in writing at the covered person's option, of:

(A) Any change to the forms or endorsement;

(B) The covered person's right to obtain, upon request and once without charge following receipt of the initial copy, a paper copy of the forms or endorsement; and

(C) The internet address at which the forms or endorsement is posted.

(b) This subsection (13) does not affect the timing or content of any disclosure or document required to be provided or made available to any covered person under applicable law.

(14) The commissioner may adopt rules to implement this section.

Source: L. 2025: Entire section added, (SB 25-010), ch. 11, p. 26, § 2, effective January 1, 2026.

Editor's note: Section 3(2) of chapter 11 (SB 25-010), Session Laws of Colorado 2025, provides that the act adding this section applies to conduct occurring on or after January 1, 2026.

PART 2

SICKNESS AND ACCIDENT INSURANCE

10-16-200.3. Definitions. As used in this part 2, unless the context otherwise requires:

(1) "Industrial sickness and accident insurance" means sickness and accident insurance under individual policies for which the premium is payable weekly and includes any such policy which covers sickness only or accident only.

Source: L. 2025: Entire section added with relocations, (SB 25-275), ch. 377, p. 2038, § 45, effective August 6.

Editor's note: This section is similar to former § 10-16-213 (1) as it existed prior to 2025.

10-16-201. Form and content of individual sickness and accident insurance policies.

(1) No such policy shall be delivered or issued for delivery in this state unless:

(a) The entire money and other considerations therefor are expressed therein; and

(b) The time at which insurance takes effect and terminates is expressed therein; and

(c) It purports to insure only one person, except as provided in sections 10-16-214 and 10-16-215, and except that a policy or contract may be issued upon the application of an adult member of a family, who shall be deemed the policyholder, covering members of any one family, including husband, wife, dependent children or any children under the age of nineteen, and other dependents living with the family; and

(d) Every printed portion of the text matter and of any endorsements or attached papers is printed in uniform type of which the face is not less than ten-point; the "text" shall include all printed matter except the name and address of the insurer, name and title of the policy, captions, subcaptions, and form numbers; but, notwithstanding any provision of this article, the commissioner shall not disapprove any such policy on the ground that every printed portion of its text matter or of any endorsement or attached paper is not printed in uniform type if it is shown that the type used is required to conform to the laws of another state in which the insurer is licensed; and

(e) The exceptions and reductions of indemnity are adequately captioned and clearly set forth in the policy or contract; and

(f) Each such form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page thereof.

(2) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state has advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in this section and sections 10-16-202 and 10-16-203.

(3) (a) Each policy in which the insurer reserves the right to refuse renewal on an individual basis shall provide, in substance, in a provision thereof or in an endorsement thereon or in a rider attached thereto, that, subject to the right to terminate the policy upon nonpayment of premium when due, the right to refuse renewal shall not be exercised before the renewal date occurring on, or after and nearest, each anniversary or, in the case of lapse and reinstatement at the renewal date, occurring on, or after and nearest, each anniversary of the last reinstatement and that any refusal of renewal shall be without prejudice to any claim originating while the policy is in force. This paragraph (a) shall not apply to accident only policies.

(b) In addition, each policy shall provide, in substance, in a provision thereof or in an endorsement thereon or in a rider attached thereto, that an insurer shall not exercise its right to refuse to renew the policy on an individual basis after two years from its date of issue or, in the event the policy has been reinstated, two years from the date of its last reinstatement and before the age or other limitation upon renewal stated in the policy solely because of deterioration in the physical or mental condition or the health of any person covered thereunder.

(c) Nothing in this subsection (3) negates the renewability requirements for health benefit plans specified in section 10-16-105.1.

(4) (a) No policy of sickness and accident insurance issued, renewed, or reinstated shall contain any provision which limits or excludes payments under hospital or medical benefits coverage to or on behalf of the insured because the insured or any covered dependent is eligible for or receiving medical assistance benefits under articles 4, 5, and 6 of title 25.5, C.R.S.

(b) The requirements of paragraph (a) of this subsection (4) shall apply to all such policies issued, renewed, or reinstated on or after August 1, 1984.

(5) (a) If a person is deployed by or called to active duty in the United States military and the person's individual sickness and accident insurance policy lapses during the deployment or activation, the insurer who insured the person shall issue, upon application, the same individual coverage to the person. The application shall contain reasonable evidence of the individual sickness and accident insurance that covered the person prior to the deployment or activation. The insurer shall not:

(I) Restrict benefits or increase premiums for the coverage as a result of the lapse in coverage;

(II) Use any health condition originating or newly treated during the lapse in coverage to rate the policy; or

(III) Limit benefits by an exclusionary rider or by applying a preexisting condition limitation provision to the policy.

(b) Nothing in this subsection (5) shall be construed to limit the ability of an insurer to increase premiums for such policies based on general rate increases that are applicable to all policyholders.

(6) An individual policy of sickness and accident insurance, other than a long-term care policy, disability income policy, or supplemental policy covering a specified disease or other limited benefit, issued, renewed, or reinstated on or after January 1, 2007, shall not contain any provision that limits or excludes payments under hospital or medical benefits coverage to or on behalf of the insured because the insured or a covered dependent sustained an injury while intoxicated or under the influence of a controlled substance, as defined in section 18-18-102 (5), C.R.S.

Source: L. 92: Entire article R&RE, p. 1658, § 1, effective July 1. **L. 2004:** (3)(c) added, p. 990, § 10, effective August 4. **L. 2005:** (5) added, p. 220, § 2, effective April 14. **L. 2006:** (4)(a) amended, p. 1999, § 37, effective July 1; (6) added, p. 408, § 1, effective January 1, 2007. **L. 2013:** (3)(c) amended, (HB 13-1266), ch. 217, p. 988, § 49, effective May 13.

Editor's note: The provisions of this section are similar to several former provisions of § 10-8-103 as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

Cross references: For the limitations concerning medical health insurance under the "Colorado Medical Treatment Decision Act", see § 15-18-111.

10-16-201.5. Renewability of health benefit plans - modification of health benefit plans. (Repealed)

Source: L. 96: Entire section added, p. 458, § 1, effective July 1. **L. 97:** Entire section amended, p. 640, § 8, effective May 1. **L. 98:** (8) added, p. 691, § 1, effective May 18. **L. 99:** IP(1), (1)(d), and (2) amended, p. 199, § 5, effective January 1, 2000. **L. 2001:** IP(6), (6)(a), and (6)(b) amended and (6)(d) added, p. 812, § 4, effective January 1, 2002. **L. 2002:** (1)(d) amended, p. 1295, § 9, effective June 7. **L. 2004:** (2) amended, p. 1319, § 1, effective May 28; (1)(f) amended, p. 990, § 11, effective August 4. **L. 2013:** Entire section repealed, (HB 13-1266), ch. 217, p. 978, § 28, effective May 13.

10-16-202. Required provisions in individual sickness and accident policies. (1) Except as provided in section 10-16-204, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) A provision as follows: "Entire contract--changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

(3) Provisions as follows: "Time limit on certain defenses: (a) Two years after the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period. The policy cannot be retroactively terminated except for fraud or intentional misrepresentation. For any termination other than for fraud or intentional misrepresentation, the carrier shall provide notice thirty days in advance of the cancellation of the policy."

"(The foregoing policy provision does not affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor limit the application of section 10-16-203 in the event of misstatement with respect to age or occupation or other insurance.)"

(A policy that the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty, or in the case of a policy issued after age forty-four, for at least five years after its date of issue, may contain, in lieu of the foregoing, the following provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption "Incontestable":

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it becomes incontestable as to the statements contained in the application.")

(b) Except for individual disability income insurance policies, no claim for loss incurred or disability, as defined in the policy, commencing one year after the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(c) If this is an individual disability income insurance policy then no claim for loss incurred or disability, as defined in this individual disability income insurance policy, commencing two years after the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(4) (a) Except as required by section 10-16-140, in a policy other than a health benefit plan, a provision as follows: "Grace period: A grace period of ..... (insert a number not less than '7' for weekly premium policies, '10' for monthly premium policies, and '31' for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

(b) A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the provision referred to in paragraph (a) of this subsection (4), "Unless not less than thirty days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

(5) (a) A provision as follows: "Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement."

(b) The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue.

(6) (a) Provisions as follows: "Notice of claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."

(b) In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the provision set forth in paragraph (a) of subsection (6) of this section:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of

such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given."

(7) A provision as follows: "Claim forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made."

(8) A provision as follows: "Proofs of loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, if such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required."

(9) A provision as follows: "Time of payment of claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

(10) (a) A provision as follows: "Payment of claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."

(b) The following provisions, or either of them, may be included with the provision set forth in paragraph (a) of this subsection (10) at the option of the insurer:

"If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give valid release, the insurer may pay such indemnity, up to an amount not exceeding $ ..... (insert an amount which shall not exceed $1000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."

"Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or

surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person."

(11) A provision as follows: "Physical examinations and autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

(12) A provision as follows: "Legal actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished."

(13) (a) A provision as follows: "Change of beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."

(b) The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

Source: L. 92: Entire article R&RE, p. 1660, § 1, effective July 1. **L. 94:** (3) amended, p. 1918, § 11, effective July 1. **L. 95:** (3)(b) amended and (3)(c) added, p. 726, § 2, effective May 23. **L. 2013:** (3) and (4)(a) amended, (HB 13-1266), ch. 217, p. 978, § 29, effective May 13.

Editor's note: This section is similar to former § 10-8-104 as it existed prior to 1992.

10-16-203. Optional provisions in individual sickness and accident insurance policies. (1) Except as provided in section 10-16-204, no individual sickness and accident insurance policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section; except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) A provision as follows: "Change of occupation: If the insured is injured or contracts sickness after having changed the insured's occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and

will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation."

(3) A provision as follows: "Misstatement of age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."

(4) A provision as follows: "Other insurance in this insurer: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured are in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $ ..... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate."; or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, the insured's beneficiary, or the estate of the insured, as the case may be, and the insurer will return all premiums paid for all other such policies.

(5) (a) A provision as follows: "Insurance with other insurers: If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage."

(b) If the foregoing policy provision is included in a policy which also contains the policy provisions in subsection (6) of this section, there shall be added to the caption of the foregoing provision the phrase "..... Expense incurred benefits". The insurer may include in this provision, at its option, a definition of "other valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition, such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service

organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage".

(6) (a) A provision as follows: "Insurance with other insurers: If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

(b) If the policy provision set forth in paragraph (a) of this subsection (6) is included in a policy which also contains the policy provision in subsection (5) of this section, there shall be added to the caption of the provision set forth in paragraph (a) of this subsection (6) the phrase "..... Other benefits". The insurer may include in this provision, at its option, a definition of "other valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition, such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefits provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision, no third-party liability coverage shall be included as "other valid coverage".

(7) (a) A provision as follows: "Relation of earnings to insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars, or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time."

(b) The policy provision set forth in paragraph (a) of this subsection (7) may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue. The insurer may include in this provision, at its option, a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition, such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations.

(8) A provision as follows: "Unpaid premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom."

(9) A provision as follows: "Conformity with state statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes."

Source: L. 92: Entire article R&RE, p. 1665, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-105 as it existed prior to 1992.

10-16-204. Inapplicable or inconsistent provisions in individual policies of sickness and accident insurance. If any provision of part 1 of this article or this part 2 is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

Source: L. 92: Entire article R&RE, p. 1669, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-106 as it existed prior to 1992.

10-16-205. Order of certain policy provisions in individual policies of sickness and accident insurance. The provisions which are the subject of sections 10-16-202 and 10-16-203, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections, or, at the option of the insurer, any such provision may appear as a unit in any part of the policy with other provisions to which it may be logically related, but the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

Source: L. 92: Entire article R&RE, p. 1669, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-107 as it existed prior to 1992.

10-16-206. Third-party ownership of individual sickness and accident insurance policies. The word "insured", as used in part 1 of this article and this part 2, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

Source: L. 92: Entire article R&RE, p. 1670, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-108 as it existed prior to 1992.

10-16-207. Requirements of other jurisdictions. (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of part 1 of this article and this part 2 and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer, when issued for delivery in any other state or country, may contain any provision permitted or required by the laws of such other state or country.

Source: L. 92: Entire article R&RE, p. 1670, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-109 as it existed prior to 1992.

10-16-208. Conforming to statute. (1) No policy provision which is not subject to section 10-16-202 or 10-16-203 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to part 1 of this article and this part 2.

(2) A policy delivered or issued for delivery to any person in this state in violation of part 1 of this article or this part 2 shall be held valid but shall be construed as provided in part 1 of this article and this part 2. When any provision in a policy subject to part 1 of this article and this part 2 is in conflict with any provision of part 1 of this article or this part 2, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of part 1 of this article and this part 2.

Source: L. 92: Entire article R&RE, p. 1670, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-110 as it existed prior to 1992.

10-16-209. Application for policy. (1) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to

any person in this state is reinstated or renewed, and the insured or the beneficiary or assignee of such policy makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer, within fifteen days after the receipt of such request at its home office or any branch office of the insurer, shall deliver or mail to the person making such request a copy of such application. If such copy is not so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

(2) No alteration of any written application for any such policy shall be made by any person other than the applicant without the applicant's written consent; except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(3) The falsity of any statement in the application for any policy covered by part 1 of this article or this part 2 may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Source: L. 92: Entire article R&RE, p. 1670, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-111 as it existed prior to 1992.

10-16-210. Notice - waiver. The acknowledgment by any insurer of the receipt of notice given under any policy covered by part 1 of this article or this part 2, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim under such policy shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

Source: L. 92: Entire article R&RE, p. 1671, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-112 as it existed prior to 1992.

10-16-211. Age limit. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which coverage provided by the policy will not be effective, and if such date falls within a period for which a premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which the premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of such premium, the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

Source: L. 92: Entire article R&RE, p. 1671, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-113 as it existed prior to 1992.

10-16-212. Exemption from attachment and execution. So much of any benefits under all policies of sickness and accident insurance as does not exceed two hundred dollars for each month during any period of disability covered by such policy shall not be liable to attachment, trustee process, or other process, or to be seized, taken, appropriated, or applied by any legal or equitable process or by operation of law, either before or after payment of such benefits, to pay any debt or liabilities of the person insured under such policy. This exemption shall not apply where an action is brought to recover for necessaries contracted for during such period and the writ or complaint contains a statement to that effect. When a policy provides for a lump sum payment because of a dismemberment or other loss insured, such payment shall be exempt from execution by the insured's creditors.

Source: L. 92: Entire article R&RE, p. 1672, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-114 as it existed prior to 1992.

10-16-213. Industrial sickness and accident insurance.

(1) Repealed.

(2) Any insurer authorized to write sickness and accident insurance in this state has the power to issue industrial sickness and accident policies.

(3) No policy of industrial sickness and accident insurance may be delivered or issued for delivery in this state unless it has printed on such policy the words "industrial policy".

(4) (a) Each such policy shall be subject to the provisions of this part 2; except that no such policy shall be required to contain any of the policy provisions set forth in section 10-16-202 or 10-16-203 and except that no such policy shall contain any provision relative to notice of proof of loss, or the time for paying benefits, or the time within which suit may be brought upon the policy, which in the opinion of the commissioner is less favorable to the insured than would be permitted by said policy provisions. Such policy may contain a provision that, upon proper written request, a named beneficiary shall be designated in or by endorsement on the policy to receive the proceeds thereof on the death of the insured, and there shall be reserved to the insured the power to change the beneficiary at any time by written notice to the insurer at its home office, accompanied by the policy for endorsement of the change on said policy by the insurer. The insurer shall have the right to refuse to designate a beneficiary if evidence satisfactory to the company of such beneficiary's insurable interest in the life of the insured is not furnished on request.

(b) Any such policy may provide in substance that any payment under said policy may be made to the insured or the insured's estate or to any relative by blood or connection by marriage of the insured, or, to the extent of such portion of any payment under the policy as reasonably appears to the insurer to be due to such person or to any other person equitably entitled thereto by reason of having incurred expense occasioned by the maintenance or illness or burial of the insured. If the policy is in force at the death of the insured, the proceeds from said policy shall be payable to the named beneficiary if living, but, upon the expiration of fifteen days after the death of the insured, unless proof of claim in the manner and form required by the policy, accompanied by the policy for surrender, has theretofore been made by such beneficiary, the insurer may pay to any other person permitted by the policy.

Source: L. 92: Entire article R&RE, p. 1672, § 1, effective July 1. **L. 2025:** (1) repealed, (SB 25-275), ch. 377, p. 2109, § 336, effective August 6.

Editor's note: (1) This section is similar to former § 10-8-115 as it existed prior to 1992.

(2) Subsection (1) was relocated to § 10-16-200.3 in 2025.

10-16-214. Group sickness and accident insurance. (1) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without their dependents, and issued upon the following bases:

(a) Under a policy issued to an employer, who shall be deemed the policyholder, insuring at least ten employees of such employer for the benefit of persons other than the employer. The term "employees", as used in part 1 of this article and this part 2, includes the officers, managers, and employees of the employer, the bona fide volunteers if the employer is an emergency service provider, the partners if the employer is a partnership, the officers, managers, and employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract, or otherwise. The term "employer", as used in part 1 of this article and this part 2, may include an emergency service provider, any municipal or governmental corporation, unit, agency, or department thereof, and the proper officers, as such, of an emergency service provider or an unincorporated municipality or department thereof, as well as private individuals, partnerships, and corporations.

(b) Under a policy issued to an association, including a labor union, which has a constitution and bylaws and which is organized and maintained in good faith for purposes other than that of obtaining insurance, insuring at least twenty-five members of the association for the benefit of persons other than the association or its officers or trustees, as such;

(c) On and after July 1, 1994, under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class of individuals that could be insured under such group life insurance policy; except that, on and after July 1, 1994, a group sickness and accident insurance policy must cover at least two or more individuals at date of issue;

(d) Under a policy issued to any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a group sickness and accident policy or contract.

(e) Repealed.

(2) (a) The provisions of this section shall not apply to transactions in this state involving group sickness and accident insurance policies for policies which were lawfully issued and delivered in another jurisdiction in which the company was authorized to do insurance business and any such policy was issued to a valid multistate association located in the state of issue, if the policy is not designed, administered, or marketed as a plan for employers to provide coverage to one or more employees and is not a bona fide association plan.

(b) Repealed.

(3) (a) Except as required by section 10-16-140 or as provided for in subsection (2) of this section, all policies of group sickness and accident insurance providing coverage to persons residing in the state must contain in substance the following provisions or provisions that, in the

opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

(I) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder has given the carrier written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the carrier for the payment of a pro rata premium for the time the coverage was in force during the grace period.

(II) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue and that no statement made for the purpose of effecting insurance coverage under the policy with respect to a person shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits under such policy after such insurance has been in force for a period of two years during such person's lifetime unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to the person making the statement or to the beneficiary of any such person;

(III) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued and that all statements made by the policyholder or by the persons covered shall be deemed representations and not warranties;

(IV) A provision that no agent has authority to change the policy or waive any of its provisions and that no change in the policy shall be valid unless approved by an officer of the insurer and evidenced by an endorsement on the policy or by rider or amendment to the policy signed by the insurer; but any such amendment which reduces or eliminates coverage shall have been either requested in writing or signed by the policyholder;

(V) (A) A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. With respect to a group health coverage plan, such provision shall comply with the provisions of section 10-16-118; except that, with respect to a group disability income insurance policy, such provision shall comply with the provisions of sub-subparagraph (C) of this subparagraph (V).

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

(C) A group disability income insurance policy shall not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health professional, or took prescription drugs within the twelve-month period immediately preceding the effective date of coverage. In no event shall a group disability income insurance policy deny, exclude, or limit benefits for a covered individual because of a preexisting condition for a disability commencing more than twelve months following the effective date of such individual's coverage under the group disability income insurance policy.

(VI) A provision specifying the ages, if any, to which the insurance provided is limited, the ages, if any, for which additional restrictions are placed on benefits, and the additional restrictions placed on the benefits at such ages. If the premiums or benefits vary by age, there shall also be a provision specifying an equitable adjustment of premiums or benefits, or both, to be made in the event the age of a covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used. In no event, however, shall coverage be required for any person during any period when, according to the person's correct age, coverage would otherwise not be provided for the person under the policy.

(VII) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, which may be in summary form, setting forth the essential features of the insurance coverage, including any applicable conversion or continuation privilege, and to whom the benefits are payable. If family members or dependents are included in the coverage, only one certificate need be issued for each family unit.

(VIII) A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(IX) A provision that the insurer will furnish, to the person making claim or to the policyholder for delivery to said person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making the claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

(X) A provision that, in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that, in the case of a claim for any other loss, written proof of such loss must be furnished to the insurer within ninety days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time if such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

(XI) A provision that all benefits payable under the policy, other than benefits for loss of time, will be payable pursuant to section 10-16-106.5 and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of such proof;

(XII) A provision that indemnity for loss of life shall be payable to the beneficiary designated by the insured (but, when the policy contains conditions pertaining to family status or provisions pertaining to coverage of family members, the beneficiary may be the family member specified by the policy terms) or, if there is no such designated or specified beneficiary, to such

other person as is specified in the policy and that all other indemnities of the policy are payable to the insured; except that the group policy may provide that all or any portion of any benefits on account of hospital, medical, and surgical or other services may be paid, at the insurer's option, directly to the hospital or person rendering such services. The group policy may provide that, if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to the provisions of this subparagraph (XII) shall discharge the insurer's obligation with respect to the extent of such payment.

(XIII) A provision that the insurer shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law;

(XIV) A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of the time requirements for payment pursuant to section 10-16-106.5 and after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy.

(b) (I) The provisions of subparagraph (V) of paragraph (a) of this subsection (3) shall not apply to dental insurance.

(II) The provisions of subparagraphs (V) and (XII) of paragraph (a) of this subsection (3) shall not apply to policies issued to a creditor to insure debtors of such creditor.

(III) The standard provisions required for individual health insurance policies shall not apply to group health insurance policies.

(IV) If any provision of this section is, in whole or in part, inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part thereof and shall modify any inconsistent provision or part thereof in such manner as to make the provision contained in the policy consistent with the coverage provided by the policy.

(4) 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.

(5) A carrier writing health benefit coverage for an employee leasing company shall ensure that any health benefit plan marketed or sold to such company that covers employees in Colorado complies with all the provisions of Colorado law that apply to large employer health plans, including consumer and provider protections, mandated benefits, nondiscrimination and fair marketing rules, preexisting limitations, and other required health plan policy provisions. All health coverage plans sponsored by or marketed through an employee leasing company shall be fully insured plans.

(6) A group sickness and accident insurance policy, other than a long-term care policy, disability income policy, or supplemental policy covering a specified disease or other limited benefit, issued, renewed, or reinstated on or after January 1, 2007, shall not contain any provision that limits or excludes payments under hospital or medical benefits coverage to or on behalf of the insured because the insured or any covered dependent sustained an injury while

intoxicated or under the influence of a controlled substance, as defined in section 18-18-102 (5), C.R.S.

Source: L. 92: Entire article R&RE, p. 1673, § 1, effective July 1; (1)(e) repealed, p. 1592, § 114, effective July 1. **L. 94:** (1)(c) and (3)(a)(V) amended, p. 1919, § 12, effective July 1. **L. 95:** (3)(a)(V)(B) amended and (3)(a)(V)(C) added, p. 726, § 3, effective May 23. **L. 97:** (2)(a) and (3)(a)(V)(A) amended and (4) added, p. 643, § 9, effective July 1. **L. 99:** (5) added, p. 149, § 3, effective March 25. **L. 2004:** (3)(a)(XI), (3)(a)(XIV), and (5) amended, p. 991, § 12, effective August 4. **L. 2006:** (6) added, p. 408, § 2, effective January 1, 2007. **L. 2008:** (1)(a) amended, p. 579, § 2, effective August 5. **L. 2010:** (1)(c) amended, (HB 10-1203), ch. 47, p. 177, § 2, effective March 29. **L. 2013:** (1)(c), IP(3)(a), and (3)(a)(I) amended and (2)(b) repealed, (HB 13-1266), ch. 217, pp. 979, 978, § § 30, 27, effective May 13.

Editor's note: (1) The provisions of this section are similar to several former provisions of § 10-8-116 as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

(2) Subsection (2)(b) was relocated to § 10-16-102 (68) in 2013.

Cross references: For the legislative declaration contained in the 1997 act amending subsections (2)(a) and (3)(a)(V)(A) and enacting subsection (4), see section 1 of chapter 154, Session Laws of Colorado 1997.

10-16-215. Blanket sickness and accident insurance. (1) Blanket sickness and accident insurance is declared to be that form of sickness and accident insurance covering special groups of not less than ten persons as enumerated under a policy or contract issued:

(a) To any common carrier, which shall be deemed the policyholder, covering a group defined as all persons who are passengers on the common carrier;

(b) To an employer, who shall be deemed the policyholder, covering all workers or any group of workers, dependents, or guests defined by reference to activities or operations of the policyholder;

(c) To a college, school, or other institution of learning or to the head or principal of the college, school, or other institution of learning, who shall be deemed the policyholder, covering students or teachers;

(d) In the name of any volunteer fire department, first aid, civil defense, or other similar volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group defined by reference to activities or operations of the policyholder;

(e) To a sports team or camp or to a sponsor of a sports team or camp, which team, camp, or sponsor shall be deemed the policyholder, covering members, campers, employees, officials, supervisors, or volunteers;

(f) To any religious, charitable, recreational, educational, or civic organization, or branch of any religious, charitable, recreational, educational, or civic organization, which organization shall be deemed the policyholder, covering all members or participants defined by reference to activities or operations of the policyholder;

(g) To a restaurant, hotel, motel, resort, or innkeeper, which shall be deemed the policyholder, covering a group defined as all persons who are patrons or guests of the policyholder;

(h) To any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a blanket sickness and accident policy or contract.

(2) An individual application shall not be required from a person covered under a blanket sickness or accident policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

(3) All benefits under any blanket sickness and accident policy shall be payable to the person insured or any such person's agent, or to the designated beneficiary of any such person, or to the estate of any such person; except that, if the person insured is a minor, such benefits may be made payable to the parent, guardian, or other person actually supporting such person.

(4) Nothing in this section relieves an employer from any requirement to obtain coverage under the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S. No policy issued under this section may qualify as or substitute for a health benefit plan under federal law. Nothing in this section affects the legal liability of policyholders for the death of or injury to any member of the group. No policy issued under this section may qualify as or substitute for general liability insurance.

Source: L. 92: Entire article R&RE, p. 1679, § 1, effective July 1. **L. 2015:** (1) amended and (4) added, (SB 15-262), ch. 294, p. 1198, § 1, effective August 5.

Editor's note: This section is similar to former § 10-8-117 as it existed prior to 1992.

10-16-216. Examinations. (1) The commissioner may, at any reasonable time, make or cause to be made an examination of every admitted health insurer transacting any insurance to which the provisions of part 1 of this article and this part 2 are applicable to ascertain whether each insurer and every rate used by it for every such class of insurance complies with the requirements and standards of this title applicable thereto. Such examination need not be a part of a periodic general examination participated in by representatives of more than one state.

(2) The officers, managers, agents, and employees of any such insurer may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation, together with all data, statistics, and information of every kind and character collected or considered by such insurer in the conduct of the operations to which such examination relates.

(3) The commissioner may conduct such examination on the basis of concern for an insurer's solvency or the complaint of a person claiming to be aggrieved or to ascertain compliance by insurers with the requirements of part 1 of this article and this part 2.

(4) Filed reports on examinations conducted pursuant to this section shall be available for public inspection at the division of insurance.

Source: L. 92: Entire article R&RE, p. 1679, § 1, effective July 1; entire section amended, p. 1592, § 115, effective July 1.

Editor's note: This section is similar to former § 10-8-118 as it existed prior to 1992.

10-16-216.5. Hearing procedure and judicial review - violations - penalty. (1) Any person aggrieved by any rate charged, underwriting rule, policy form, certificate, contract of insurance, or rider followed or adopted by a health insurer may request the insurer to review the manner in which the rate, underwriting rule, policy form, certificate, contract of insurance, or rider has been applied with respect to insurance afforded to any such person. Such request may be made by an authorized representative of any such person and shall be written. If the request is not granted within thirty days after it is made, the request may be treated as rejected. Any person aggrieved by the action of an insurer in refusing the review requested may file a written complaint and request for hearing with the commissioner, specifying the grounds relied upon. If the commissioner finds that probable cause for the complaint does not exist or that the complaint is not made in good faith, the commissioner shall deny the hearing; however, if the commissioner finds that the complaint charges a violation of any provision of this article and that the complainant would be aggrieved if the violation is proven, the commissioner shall proceed as provided in subsection (2) of this section.

(2) If after examination or inspection of an insurer, or upon the basis of other information, or upon sufficient complaint as provided in subsection (1) of this section, the commissioner has good cause to believe that such insurer, or any rate, underwriting rule, policy form, certificate, contract of insurance, or rider made or used by any such insurer does not comply with the applicable requirements and standards, the commissioner shall, unless the commissioner has good cause to believe such noncompliance is willful, give notice in writing to such insurer, stating therein in what manner and to what extent such noncompliance is alleged to exist and specifying therein a reasonable time, not less than ten days thereafter, in which such noncompliance shall be corrected.

(3) (a) If the commissioner has good cause to believe that noncompliance with the applicable requirements and standards as specified in subsection (2) of this section is willful or if, within the period prescribed by the commissioner in the notice required by subsection (2) of this section, the insurer does not make such changes as may be necessary to correct the noncompliance specified by the commissioner or establish to the satisfaction of the commissioner that such specified noncompliance does not exist, the commissioner may hold a public hearing in connection therewith. Within a reasonable period of time, not less than ten days before the date of such hearing, the commissioner shall mail a written notice of the hearing to such insurer. The notice given under this subsection (3) shall state in what manner and to what extent noncompliance is alleged to exist and the matter to be considered at such hearing. The hearing shall not include subjects not specified in the notice. The hearing shall be conducted in accordance with section 24-4-105, C.R.S., and the commissioner shall have all the powers set forth in said section.

(b) Any insurer aggrieved by an order or decision of the commissioner made without a hearing may, within thirty days after notice of the order or decision, make written application to the commissioner for a hearing thereon. The commissioner shall hold a hearing as provided in the applicable provisions of article 4 of title 24, C.R.S. Within fourteen days after such hearing, the commissioner shall affirm, reverse, or modify the commissioner's previous action, specifying the reasons therefor.

(4) If, after a hearing pursuant to subsection (3) of this section, the commissioner finds:

(a) That any rate violates the provisions of this title applicable to it, the commissioner may issue an order to the insurer which has been the subject of the hearing, specifying in what respects such violation exists and stating when, within a reasonable period of time, the further use of such rate by such insurer in contracts of insurance made thereafter shall be prohibited. In such order the commissioner shall require the excess premium plus eight percent interest to be refunded to the policyholder. The amount of the refund, plus interest, shall be computed from the effective date of the rate used on the policyholder contract to the date of the order by the commissioner pursuant to this section. Interest shall be computed as simple interest per annum.

(b) That an insurer is in violation of the provisions of this title applicable to it, other than the provisions dealing with rates, the commissioner may issue an order to such insurer which has been the subject of the hearing, specifying in what respect such violation exists and requiring compliance within a specified time thereafter;

(c) That any policy form, certificate, contract of insurance, or rider contains any provision or style of presentation which is deceptive or misleading or renders its use hazardous to the public or the policyholders or otherwise does not comply with the requirements of law, the commissioner may issue an order to such insurer which has been the subject of the hearing, prohibiting the further use of such form in this state;

(d) That the violation of any of the provisions of this title applicable to it by any insurer which is the subject of a hearing is willful, the commissioner may suspend or revoke, in whole or in part, the certificate of authority of such insurer with respect to the class of insurance which has been the subject matter of the hearing.

(5) In addition to any other remedies or penalties provided by law:

(a) The commissioner may suspend or revoke, in whole or in part, the certificate of authority of any insurer which fails to comply with an order of the commissioner within the time limit contained in any such order. The commissioner shall not suspend or revoke the certificate of authority for failure to comply with an order until the time prescribed for an appeal therefrom has expired or, if an appeal has been taken, until such order has been affirmed. The commissioner may determine when a suspension or revocation of any certificate of authority shall become effective. An order of suspension shall remain in effect for the period fixed by the commissioner unless the commissioner modifies or rescinds such suspension or until the order upon which such suspension is based is modified, rescinded, or reversed. No certificate of authority shall be suspended or revoked except upon a written order of the commissioner, stating findings made after a hearing held upon not less than ten days' written notice to such person or organization specifying the alleged violations.

(b) If a failure to comply with an order of the commissioner within the time limit specified in any such order is willful, the insurer shall be liable to the state in an amount not exceeding five thousand dollars for any such failure. The commissioner shall collect the amount so payable and may bring a civil action in the name of the people of the state of Colorado to enforce such collection. Such penalty may be in addition to the remedy provided in paragraph (a) of this subsection (5). All moneys collected by the commissioner under this paragraph (b) shall be transmitted to the state treasurer who shall credit the same to the general fund of the state.

(6) Any finding, determination, rule, ruling, or order made by the commissioner pursuant to this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 92: Entire section added, p. 1593, § 116, effective July 1.

10-16-217. Application of part 1 of this article and part 2. (1) Nothing in part 1 of this article or this part 2 shall apply to or affect any policy of workers' compensation insurance or any policy of liability insurance with or without supplementary expense coverage in said policy; or life insurance, endowment, or annuity contracts, or contracts supplemental to said policy which contain only such provisions relating to sickness and accident insurance as provide additional benefits in case of death by accident, and as operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

(2) With the exception of section 10-16-201 (3), the provisions of sections 10-16-201 to 10-16-205 shall not apply to those forms of sickness and accident policies enumerated in sections 10-16-214 and 10-16-215; except that no such policy shall contain any provision relative to notice or proof of loss, or the time for paying benefits, or the time within which suit may be brought upon the policy, which in the opinion of the commissioner is less favorable to the insured than would be permitted by the policy provisions set forth in section 10-16-202 or 10-16-203.

Source: L. 92: Entire article R&RE, p. 1680, § 1, effective July 1.

Editor's note: This section is similar to former § 10-8-119 as it existed prior to 1992.

Cross references: For provisions pertaining to workers' compensation, see articles 40 to 47 of title 8.

10-16-218. Judicial review. Any final action of the commissioner pursuant to part 1 of this article and this part 2 shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 92: Entire article R&RE, p. 1680, § 1, effective July 1; entire section amended, p. 1596, § 118, effective July 1.

Editor's note: This section is similar to former § 10-8-120 as it existed prior to 1992.

10-16-219. Benefits for care in tax-supported institutions - behavioral health disorders - mental health disorders - intellectual and developmental disabilities. (1) On and after July 1, 1977, an individual or group policy of sickness, health, or accident insurance or small group sickness and accident insurance delivered or issued for delivery to any person in this state that provides coverage for behavioral or mental health disorders or intellectual and developmental disabilities must not exclude or be construed to diminish benefits for the payment of the direct costs, related directly to the treatment of such behavioral or mental health disorders or intellectual and developmental disabilities, provided by a state institution, including community clinics and centers providing services for persons with behavioral or mental health disorders or intellectual and developmental disabilities if the charges for treatment of such

behavioral or mental health disorders or intellectual and developmental disabilities are customarily charged to nonindigent patients by the state institution.

(2) Any policy issued on or after July 1, 1977, on a form approved prior to said date, containing any provisions in conflict with the provisions of this section shall be in effect only if there is attached to such policy at the time of issue a rider or endorsement amending such policy to conform to the provisions of this section.

Source: L. 92: Entire article R&RE, p. 1680, § 1, effective July 1. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1266, § 38, effective May 25.

Editor's note: This section is similar to former § 10-8-123 as it existed prior to 1992.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

10-16-220. Minimum standards for sickness and accident plans. The commissioner may promulgate regulations prescribing minimum standards applicable to the valuation of sickness and accident plans or products, and in conformance with standards as adopted by the national association of insurance commissioners.

Source: L. 92: Entire section added, p. 1498, § 28, effective July 1.

Editor's note: This section was enacted by section 28 of chapter 203, Session Laws of Colorado 1992, as § 10-8-127 but was renumbered on revision and harmonized with this article since part 1 of article 8 was repealed and the substantive provisions thereof were moved to this article.

10-16-221. Statewide health care review committee - creation - membership - duties - repeal. (1) The statewide health care review committee is hereby created in order to study health-care issues that affect Colorado residents throughout the state, including the following:

(a) Emerging trends in Colorado health care and their effects on consumers, providers, and payers;

(b) The ability of consumers to obtain and keep adequate, affordable health insurance coverage;

(c) The effect of changes in the way health care is delivered and paid for;

(d) Trends in health-care coverage rates for individuals, employees, and employers and in reimbursement rates for health-care services;

(e) Access to and availability of federal funds and waivers of federal law;

(f) Innovations in health care and health-care coverage;

(g) Health-care issues that arise in or are unique to rural areas of the state;

(h) Access to timely and quality health care and emergency and nonemergency medical transportation;

(i) Options for addressing the needs of uninsured and underinsured populations;

(j) Issues related to the health-care workforce, including network adequacy and the adequacy of access to providers; and

(k) Any other health-care issue affecting Colorado residents that the committee deems necessary to study.

(2) (a) The committee consists of no more than ten members from the house of representatives committees on health and insurance and public health care and human services and the senate committee on health and human services, or their successor committees.

(b) The chair of the house of representatives committee on health and insurance or its successor committee shall chair the committee in odd-numbered years and serve as the vice-chair of the committee in even-numbered years. The chair of the senate committee on health and human services or its successor committee shall chair the committee in even-numbered years and serve as the vice-chair of the committee in odd-numbered years.

(c) The staff of the legislative council and of the office of legislative legal services shall assist the committee in carrying out its duties under this section.

(3) (a) The committee shall meet no more than two times each legislative interim, unless additional meetings are authorized by the executive committee of the legislative council. Of the meetings authorized under this subsection (3), the committee may take up to two field trips per year in connection with its duties mandated under this section.

(b) Repealed.

(c) (I) Notwithstanding subsection (3)(a) of this section, the committee shall not meet or take field trips during the 2025 interim.

(II) This subsection (3)(c) is repealed, effective July 1, 2026.

Source: L. 2005: Entire section added, p. 1026, § 2, effective June 2; (2)(n) added, p. 576, § 1, effective May 26. **L. 2006:** (2.5) added, p. 720, § 1, effective May 1; (2)(m) and (2)(n) amended and (2)(o) added, p. 1172, § 1, effective May 25. **L. 2007:** (2.6) added, p. 1258, § 1, effective May 25. **L. 2009:** (2.7) added, (HB 09-1102), ch. 93, p. 358, § 1, effective April 3; (1)(b) amended, (HB 09-1364), ch. 364, p. 1912, § 1, effective June 1; (2.8) added, (HB 09-1224), ch. 274, p. 1236, § 1, effective August 5. **L. 2010:** (1)(f) amended, (SB 10-213), ch. 375, p. 1761, § 5, effective June 7. **L. 2019:** Entire section RC&RE, (SB 19-015), ch. 370, p. 3382, § 1, effective May 30. **L. 2020:** (3) amended, (SB 20-214), ch. 200, p. 981, § 6, effective June 30. **L. 2025:** (3)(c) added, (SB 25-199), ch. 149, p. 567, § 5, effective April 30.

Editor's note: (1) Prior to the recreation of this section in 2019, subsection (4) provided for the repeal of this section, effective July 1, 2010. (See L. 2005, p. 1026.)

(2) Subsection (3)(b)(II) provided for the repeal of subsection (3)(b), effective July 1, 2021. (See L. 2020, p. 981.)

10-16-222. Termination of policies. A carrier shall not retroactively terminate a policy issued pursuant to this part 2 except for fraud or intentional misrepresentation. For any termination other than for fraud or intentional misrepresentation, the carrier shall provide notice thirty days in advance of the cancellation of the policy.

Source: L. 2013: Entire section added, (HB 13-1266), ch. 217, p. 980, § 31, effective May 13.

PART 3

10-16-301. Legislative declaration. (1) It is the policy of the general assembly, and the intent and purpose of this article, to promote the availability of hospital care, medical-surgical care, and other health services on a voluntary nonprofit prepaid basis, and to thereby promote the health and welfare of the people of the state of Colorado.

(2) It is further the policy of the general assembly to conform the laws of the state of Colorado to section 1012 of the federal "Tax Reform Act of 1986", as amended, to ensure uniform federal and Colorado income taxation treatment of nonprofit hospitals, medical-surgical, and health service corporations. The general assembly recognizes that health-care coverage may be offered to the citizens of this state by various entities with distinct organizational and functional forms. The placement of this part 3 in this article should in no way be construed so as to alter the distinct organizational and functional character of nonprofit hospital, medical-surgical, and health service corporations or to alter the legal distinctions between such corporations and other health-care coverage entities.

Source: L. 92: Entire article R&RE, p. 1681, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-102 as it existed prior to 1992.

10-16-302. Incorporation and organization - exemptions. (1) Any nonprofit corporation organized under the laws of Colorado for the purpose of establishing, maintaining, and operating a nonprofit plan whereby prepaid hospital care, medical-surgical care, and other health services are made available to persons who become subscribers to the plan under a contract with the corporation, or for the purpose of providing long-term care insurance to persons pursuant to a contract with the corporation is subject to and governed by part 1 of this article 16 and this part 3 and, except as provided in this article 16 and elsewhere in this title 10, is not subject to the laws of this state relating to insurance or insurance companies. The provisions of section 10-3-128; articles 1 and 2 of this title 10; and parts 4, 5, 7, 8, 11, 12, and 16 of article 3 of this title 10, to the extent applicable, govern corporations organized pursuant to this part 3.

(2) The provisions of this part 3 shall not apply to any employer's health plan or services established and maintained solely for its employees and their immediate families, nor to any labor organization's health plan or services established and maintained solely for its members and their immediate families, which plans or services are self-insured, nor to any such health plan or services established, maintained, and insured jointly by any employer and any labor organization.

Source: L. 92: Entire article R&RE, p. 1681, § 1, effective July 1; (1) amended, p. 1597, § 118, effective July 1. **L. 94:** (1) amended, p. 596, § 2, effective April 7; (1) amended, p. 1648, § 90, effective May 31. **L. 2001:** (1) amended, p. 1050, § 33, effective July 1. **L. 2013:** (1) amended, (HB 13-1115), ch. 338, p. 1972, § 11, effective March 31, 2015. **L. 2016:** (1) amended, (SB 16-189), ch. 210, p. 757, § 16, effective June 6. **L. 2019:** (1) amended, (HB 19-1291), ch. 188, p. 2094, § 4, effective August 2.

Editor's note: (1) This section is similar to former § 10-16-103 as it existed prior to 1992.

(2) Amendments to subsection (1) by Senate Bill 94-206 and House Bill 94-1275 were harmonized.

10-16-303. Filing of articles of incorporation. (1) Whenever any number of persons associate to form a corporation for any of the purposes named in section 10-16-302, they shall submit articles of incorporation which shall be issued in triplicate to the commissioner and the attorney general for examination. After being approved by such officers, the articles shall be filed and recorded in the office of the secretary of state who shall issue a certificate of incorporation. A copy of such articles, certified by the secretary of state, shall be filed with the commissioner.

(2) When not less than the amount required by section 10-16-310 is deposited with the commissioner, as provided for in this part 3, the commissioner shall cause an examination to be made either by the commissioner or some disinterested person, especially appointed by the commissioner for the purpose, who shall certify that the provisions of part 1 of this article and this part 3 have been complied with by said corporation, as far as applicable thereto. Such certificate shall be filed in the office of the commissioner, who shall thereupon deliver to such corporation a certified copy thereof, which, together with a copy of the articles of incorporation, shall be filed in the office of the clerk and recorder of the county wherein the principal office of the company is to be located, before the authority to commence business is granted.

(3) Whenever any such corporation thereafter desires to amend its articles of incorporation, it shall file its certificate of amendment with the commissioner before filing the same with the secretary of state, and if the commissioner, with the advice of the attorney general, finds the same to have been legally adopted and to be in due legal form and not in conflict with the provisions of law governing such corporations, then, and not otherwise, such certificate of amendment shall be filed with the secretary of state.

(4) Any corporation organized under the laws of this state relating to corporations not for profit prior to July 1, 1967, for the purposes named in section 10-16-302, shall within one year after July 1, 1967, comply with all of the provisions of this section and shall thereupon become subject to and be governed by said provisions.

Source: L. 92: Entire article R&RE, p. 1682, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-104 as it existed prior to 1992.

10-16-304. Contents of articles. (1) In addition to the contents required or permitted by the general corporation laws of this state relating to corporations not for profit, the articles of incorporation of any corporation shall comply with the following:

(a) The name of the corporation shall not include the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business. The corporate name of any corporation formed under this article shall not be the same as and shall be distinguishable on the records of the secretary of state from the name of any other corporation authorized to do business in this state; and

(b) The statement of purposes shall be in conformity with the provisions of part 1 of this article and this part 3.

(2) Any such corporation organized prior to July 1, 1967, whose existing articles of incorporation shall not be in substantial conformity with part 1 of this article and this part 3 shall forthwith cause to be adopted and filed, as required in part 1 of this article and in this part 3 such amendments thereto as shall be necessary to effect substantial compliance with part 1 of this article and this part 3.

Source: L. 92: Entire article R&RE, p. 1683, § 1, effective July 1. **L. 2000:** (1)(a) amended, p. 988, § 103, effective July 1.

Editor's note: This section is similar to former § 10-16-105 as it existed prior to 1992.

Cross references: For corporation laws relating to corporations not for profit, see article 40 of title 7.

10-16-305. Directors. (1) The property and lawful business of every such corporation subject to the provisions of part 1 of this article and this part 3 shall be held and managed by a board of trustees or directors with such powers and authority as shall be necessary or incidental to the complete execution of the purposes of each such corporation as limited by its articles or the bylaws. No such board shall be composed of less than ten nor more than twenty-four members. Every such corporation with annual gross subscription income exceeding one million dollars shall have a majority of its board consisting of persons who are not:

(a) Members of the medical or nursing profession; or

(b) Employed by a hospital or clinic or employed by a corporation subject to part 1 of this article and to this part 3; or

(c) Otherwise directly or indirectly connected with hospitals or licensed health-care institutions or purveyors of health services in this state.

(2) It is the duty of all members of a board of trustees or directors to represent the interests of the subscribers or members of health service plans of such corporation.

(3) Any such corporation subject to the provisions of part 1 of this article and this part 3 shall keep correct and complete books and records of account and shall keep minutes of the proceedings of its board of trustees or directors and committees having authority of the board of trustees, and shall keep at its registered office or principal office in this state a record of the names and addresses of its subscribers or members of the health service plans of such corporation. All books and records, excluding privileged medical records and personal records of subscribers or members, of such corporation may be inspected by any subscriber, or his agent or attorney at the registered or principal office of the corporation, for any proper purpose at any reasonable time.

Source: L. 92: Entire article R&RE, p. 1683, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-106 as it existed prior to 1992.

10-16-306. Contracts - benefits for long-term care insurance. Corporations subject to the provisions of part 1 of this article and this part 3 may enter into contracts for the rendering of long-term care insurance, as defined in section 10-19-103 (5), on behalf of any of their subscribers. Such contracts shall comply with article 19 of this title.

Source: L. 92: Entire article R&RE, p. 1684, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-107 as it existed prior to 1992.

10-16-307. Authority to do business. No corporation subject to the provisions of part 1 of this article and this part 3 shall transact any business in this state unless it first procures from the commissioner a certificate of authority stating that the requirements of the laws of this state have been complied with and authorizing it to do business. The certificate of authority shall expire on June 30 each year and shall be renewed annually if the corporation has continued to comply with the provisions of part 1 of this article and this part 3.

Source: L. 92: Entire article R&RE, p. 1684, § 1, effective July 1; entire section amended, p. 1597, § 119, effective July 1.

Editor's note: This section is similar to former § 10-16-110 as it existed prior to 1992.

10-16-308. Automatic extension of certificate. When the annual statement of a corporation subject to the provisions of part 1 of this article and this part 3 has been filed and all fees due from the corporation have been tendered, the corporation's certificate of authority to do business in this state shall automatically be extended until such time as the commissioner refuses to relicense such corporation, and when the fee involved in the renewal of an enrollment representative's license has been tendered by the corporation, or the individual representative, the license shall automatically be extended until such time as the commissioner refuses to renew such license.

Source: L. 92: Entire article R&RE, p. 1685, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-111 as it existed prior to 1992.

10-16-309. Requirements for certificate of authority. (1) The commissioner shall not issue or renew a certificate of authority to any corporation operating or proposing to operate a nonprofit hospital, medical-surgical, and other health services plan, unless:

(a) The subscription or membership certificates which the corporation offers to its subscribers or members, together with a schedule of the dues and fees to be paid by subscribers or members, have been filed with the commissioner in accordance with the provisions of section 10-16-107;

(b) The schedule of the dues and fees to be paid by subscribers or members is such as will enable such corporation to meet the expenses of the hospital, medical-surgical, and other health services which are made available to its subscribers or members without impairing the guarantee fund required by section 10-16-310.

Source: L. 92: Entire article R&RE, p. 1685, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-112 as it existed prior to 1992.

10-16-310. Surplus - guarantee fund deposit - regulations. (1) No corporation subject to the provisions of part 1 of this article and this part 3 shall be permitted to do any business in this state unless, in addition to the other requirements of law, it has and maintains surplus in an amount not less than five percent of the corporation's subscription income collected in the preceding year, not exceeding two million dollars, plus two and one-half percent of such income exceeding two million dollars but not exceeding ten million dollars, plus one percent of such income exceeding ten million dollars; but, in no event shall such surplus be less than one hundred thousand dollars. All corporations subject to the provisions of part 1 of this article and this part 3 shall place on deposit with the commissioner a guarantee fund of cash or approved securities in an amount determined by such formula, but not less than one hundred thousand dollars nor more than one million five hundred thousand dollars. Any amount of said surplus required by this subsection (1) and subsection (3) of this section in excess of one million five hundred thousand dollars shall be maintained by the corporation at all times, but shall not be required to be placed on deposit with the commissioner.

(2) The cash or securities representing the guarantee fund required by this section shall be deposited with the commissioner under joint control in the same manner as prescribed in sections 10-3-206, 10-3-210, and 10-3-211.

(3) The regulations authorized in this subsection (3) are to be promulgated to avoid situations where the transactions of a corporation subject to the provisions of part 1 of this article and this part 3 would create undue financial risks to its subscribers or the people of this state. The commissioner may by regulation establish standards consistent with the risk-based capital models applicable to hospital, medical, and dental service or indemnity corporations developed or adopted by the national association of insurance commissioners which require any such corporation to maintain a greater minimum level of surplus than the specified dollar minimums established by subsection (1) of this section. Such minimum level of surplus shall reflect the type, volume, and nature of the business being transacted. Such regulations may additionally require the submission of an opinion by a qualified actuary which states whether or not the surplus level of the entity is sufficient.

Source: L. 92: Entire article R&RE, p. 1685, § 1, effective July 1; (2) amended, p. 1597, § 120, effective July 1. **L. 94:** (1) amended and (3) added, p. 596, § 3, effective April 7. **L. 96:** (2) amended, p. 97, § 2, effective July 1.

Editor's note: This section is similar to former § 10-16-113 as it existed prior to 1992.

10-16-311. Group benefits for depositors of banks - benefits for subscribers in public institutions. (1) Nonprofit hospitals and health service corporations may contract with any bank located and doing business in any community in this state, the population of which does not exceed ten thousand inhabitants, as shown by the last preceding federal census, to provide group hospital and medical benefits for the depositors of such bank if the premiums are paid by the bank as holder of the master contract from authorized deductions from individual

member depositors' accounts in such bank in accordance with applicable laws governing such deductions.

(2) (a) No certificate issued, renewed, or reinstated by a corporation subject to the provisions of part 1 of this article and this part 3 shall contain any provision which limits or excludes payments under hospital or medical benefits coverage to or on behalf of the subscriber because the subscriber or any covered dependent is eligible for or receiving medical assistance benefits under articles 4, 5, and 6 of title 25.5, C.R.S.

(b) The requirements of paragraph (a) of this subsection (2) shall apply to all such certificates issued, renewed, or reinstated on or after August 1, 1984.

Source: L. 92: Entire article R&RE, p. 1686, § 1, effective July 1. **L. 2006:** (2)(a) amended, p. 1999, § 38, effective July 1.

Editor's note: The provisions of this section are similar to several former provisions of § 10-16-114 as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

10-16-312. Contracts with other organizations. Any corporation subject to the provisions of part 1 of this article and this part 3 may contract with any agency, instrumentality, or political subdivision of the United States of America, or of the state of Colorado for the making available of hospital, medical-surgical, and other health-care services, and in aid or furtherance of such contract may accept, receive, and administer in trust, funds directly or indirectly made available by such agency, instrumentality, or political subdivision. Any such corporation may also subcontract with any organization which has contracted with any agency, instrumentality, or political subdivision of the United States of America or of the state of Colorado for the furnishing of hospital, medical-surgical, or other health services by which subcontract such corporation undertakes to furnish the services specified by the basic contract. Any corporation subject to the provisions of part 1 of this article and this part 3 may also enter into agreements or contracts with other similar organizations or corporations licensed to do business in this state or any other state for the transfer of subscribers or members, for the reciprocal or joint provision of benefits to the subscribers or members of such corporation and such organizations, or such other joint undertakings as the corporation's board of directors or trustees may approve.

Source: L. 92: Entire article R&RE, p. 1687, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-116 as it existed prior to 1992.

10-16-313. Licensing of representatives. (Repealed)

Source: L. 92: Entire article R&RE, p. 1687, § 1, effective July 1; (2) amended, p. 1598, § 121, effective July 1. **L. 94:** Entire section repealed, p. 597, § 4, effective April 7.

Editor's note: Prior to its repeal in 1994, the provisions of this section were similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

10-16-314. Payment for examinations of corporations. A corporation periodically examined by the commissioner shall pay to the commissioner the cost of such examination, as determined by the commissioner.

Source: L. 92: Entire article R&RE, p. 1688, § 1, effective July 1. **L. 94:** Entire section amended, p. 598, § 5, effective April 7.

Editor's note: This section is similar to former § 10-16-120 as it existed prior to 1992.

10-16-315. Revocation of certificate - appeal. (1) The commissioner shall not make public the result of any examination or investigation of any corporation found to be insolvent or with its capital impaired prior to suspending or revoking the authority of such company to do business in this state. If the commissioner determines, after examination, hearing, or other evidence, that such corporation is in an unsound condition, or has failed to comply with the law, or with the provisions of its charter, or that its condition is, or its methods are, such as to render its operations hazardous to the public, or to its subscribers, or that its actual assets, exclusive of its capital, are less than its liabilities, or if its officers or agents refuse to submit to examination, or to perform any legal obligation relative thereto, or refuse on behalf of the corporation to pay the examination charges, the commissioner shall suspend or revoke all certificates of authority granted to said corporation, and to its officers or agents, and shall cause notice thereof to be published in one or more daily newspapers published in the city and county of Denver, which shall have a general state circulation, and no solicitation of new business shall thereafter be done by it or its agents in this state while such default or disability continues, nor until its authority to do business is restored. Before suspending or revoking the certificate of authority of any such corporation, unless it is insolvent or its capital impaired, the commissioner shall grant fifteen days in which to show cause why such action should not be taken.

(2) A corporation whose certificate of authority has been suspended or revoked by the commissioner, may appeal any such action to the court of appeals pursuant to section 24-4-106 (11), C.R.S.

(3) The court has the power to make an order suspending or staying the order of the commissioner suspending or revoking the license of a corporation pending the appeal; but the corporation appealing shall give a bond, with sureties satisfactory to the court, in such amount as the court determines to be just and proper, conditioned to pay to the state and to any persons whomsoever any loss that may be sustained by reason of the stay or suspension of such order of said commissioner, and that during the period allowed for taking such appeal, the publication of notice of the revocation or suspension of license of such corporation as provided by this section shall not be made. If the order of the commissioner has been stayed or suspended by the order of said court, such publication shall not be made until after the discharge of such stay or until the affirmation of such order of revocation or suspension.

(4) (Deleted by amendment, L. 92, p. 1598, § 122, effective July 1, 1992.)

(5) (a) In the event of such a finding of insolvency, the commissioner shall have and exercise all of the powers and authority set forth in part 5 of article 3 of this title.

(b) (Deleted by amendment, L. 92, p. 1598, § 122, effective July 1, 1992.)

Source: L. 92: Entire article R&RE, p. 1689, § 1, effective July 1; (2), (4), and (5)(b) amended, p. 1598, § 122, effective July 1.

Editor's note: This section is similar to former § 10-16-121 as it existed prior to 1992.

10-16-316. Complaints. Any individual subscriber of a corporation subject to the provisions of part 1 of this article and this part 3 who is aggrieved by any act or omission of such corporation or its officers, directors, agents, or representatives, may file a statement in writing of such grievance in the office of the commissioner and the commissioner may make such investigation of such grievance as the commissioner deems appropriate. No such investigation by the commissioner shall act as a bar to any suit in a court of competent jurisdiction instituted by any such member or subscriber, or any defense thereto by the corporation involved.

Source: L. 92: Entire article R&RE, p. 1691, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-122 as it existed prior to 1992.

10-16-317. Exemption of direct payment methods. Nothing contained in part 1 of this article or this part 3 shall be construed to affect or apply to hospitals, or other licensed health-care institutions, nor to any individuals, partnerships, associations, or corporations which are the direct purveyors of health services; nor shall anything contained in part 1 of this article or this part 3 be construed to in any way limit the rights of such hospitals, or other licensed health-care institutions or purveyors of health services, to establish methods of payment directly with the purchasers of their services; except such methods of payment by all corporations subject to part 1 of this article and this part 3 shall be on a prospective reimbursement basis as required by section 10-16-318; but the commissioner may require from any such institution or purveyor of services such information as will enable the commissioner to determine whether any such arrangements for payment for services are subject to the provisions of part 1 of this article and this part 3.

Source: L. 92: Entire article R&RE, p. 1691, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-124 as it existed prior to 1992.

10-16-317.5. Assignment of benefits. (1) An individual or group nonprofit hospital or medical service contract issued pursuant to the provisions of this article shall not prohibit a subscriber under the contract from assigning, in writing, benefits payable under the contract to a licensed hospital or other licensed health-care provider for services provided to the subscriber which are covered under the contract.

(2) When a licensed hospital or other licensed health-care provider receives an assignment from a subscriber it is the responsibility of the provider to bill the contract issuer,

including a copy of the assignment, and to mail a copy of such bill to the subscriber or certificate holder, stating on such copy that it is for informational purposes only and that the payer has been billed for covered benefits. The issuer of such nonprofit hospital or medical service contract shall honor such assignment and make payment of covered benefits directly to such licensed hospital or other licensed health-care provider. In the event the issuer fails to honor such assignment by making payment to the subscriber and the subscriber, upon receipt of such payment, fails to timely pay an amount equivalent to such payment to the licensed hospital or other licensed health-care provider, then the issuer shall be liable for such covered benefits payment directly to the licensed hospital or other licensed health-care provider. It shall be the responsibility of the licensed hospital or other licensed health-care provider to notify the issuer if timely payment has not been received. In such case, the issuer shall make payment of covered benefits pursuant to section 10-3-1110 (2) within thirty days after receipt of such notification.

(3) (a) Nothing in this section shall be construed to limit any nonprofit hospital, medical-surgical, and health-care service corporation from determining the scope of its benefits or services or any other terms of its subscriber contracts, nor from negotiating contracts with licensed providers on reimbursement rates or any other lawful provisions.

(b) Notwithstanding the provisions of subsection (2) of this section, a licensed provider shall not be entitled to payment greater than the lesser of its charges or any level of reimbursement previously negotiated with any nonprofit hospital, medical-surgical, and health-care service corporation, if applicable; nor shall such payer have any obligation under this section except for covered benefits.

(4) Nothing in this section shall be construed to prevent any nonprofit hospital, medical-surgical, and health-care service corporation from limiting covered benefits to services provided by providers who have contracted with such corporation or from providing different levels of benefits depending on whether the provider has or has not contracted with such corporation.

Source: L. 92: Entire section added, p. 1772, § 1, effective May 20.

Editor's note: (1) Although the effective date for the repeal and reenactment of this article was July 1, 1992, this section was added, effective May 20, 1992.

(2) This section was enacted as § 10-16-124.5 but, because of the repeal and reenactment of this article, was renumbered on revision for ease of location.

10-16-318. Prospective reimbursement. (1) No corporation subject to the provisions of part 1 of this article and this part 3 which provides a service contract as distinguished from a fixed dollar benefit contract shall provide reimbursement for the rendering of hospital care, medical-surgical care, or other health services on behalf of any of its members or subscribers with hospitals except by contract which provides for reimbursement on a prospective reimbursement basis. As used in this part 3, "prospective reimbursement" means a method of reimbursement whereby the purveyor of health services is reimbursed by each corporation subject to part 1 of this article and this part 3 for such services according to a schedule of rates, determined and agreed upon prior to the rendering of the services by both the purveyor of health services and each corporation subject to the provisions of part 1 of this article and this part 3. Such rates are to remain in force during the term of the contract or for one calendar year if a contract has a longer term, except as adjusted as provided in this section.

(2) (a) The bases for the prospective reimbursement rates shall be:

(I) Determined mutually by the corporation and the hospital using established accounting principles and regulations utilized in the health-care industry for the determination of reimbursement to purveyors. Historic expenses may be one of the bases for reimbursement but not the sole basis.

(II) Supported by current and predicted costs derived through an appropriate budget and accounting system of the hospital, which budget and accounting system shall be available for discussion in detail with the corporation.

(b) The hospitals' operating requirements and the services offered, geographical characteristics, and the changes in price level indices may be included in the bases for prospective reimbursement.

(c) All such contracts shall be, if deemed necessary and only after the parties have exhausted all other efforts, subject to arbitration by the commissioner under the rules and regulations established by such commissioner.

(3) In order to provide incentives for the efficient and economical utilization of purveyor resources, the reimbursement rate agreed upon by the purveyor and the corporation subject to part 1 of this article and this part 3 shall be neither retroactively increased to reflect unforeseen patient costs nor retroactively decreased as a result of efficient purveyor operation. However, gains accruing to the purveyor as a result of a modification of those patient services, of operating requirements, or of changes in price level indices which were included in the bases for the setting of the prospective rate will be subject to downward adjustment.

(4) Provision shall be made between corporations subject to part 1 of this article and this part 3 and the purveyor of health-care services for a mechanism to determine adjustments of prospectively determined rates. Such adjustments will occur when major events that have a fiscal impact occur which were unpredictable or were uncontrollable by the purveyor of health-care services and which would require a rate change to meet the financial requirements of the purveyor of health-care services.

(5) Corporations subject to part 1 of this article and this part 3 shall not pay more for purveyor's services than will be charged to commercial insurers.

(6) Each corporation subject to the provisions of part 1 of this article and this part 3 shall provide the commissioner with a copy of each contract entered into under this section, within thirty days after such contract is entered into, and such other information as the commissioner deems necessary by rule.

Source: L. 92: Entire article R&RE, p. 1691, § 1, effective July 1. **L. 96:** (6) amended, p. 1230, § 53, effective August 7.

Editor's note: This section is similar to former § 10-16-130 as it existed prior to 1992.

Cross references: For the legislative declaration contained in the 1996 act amending subsection (6), see section 1 of chapter 237, Session Laws of Colorado 1996.

10-16-319. Effective date. Sections 10-16-317 and 10-16-318 shall take effect January 1, 1974, and shall be implemented with the beginning of each hospital's fiscal year.

Source: L. 92: Entire article R&RE, p. 1693, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-133 as it existed prior to 1992.

10-16-320. Investment of funds. The investable funds of a corporation subject to the provisions of part 1 of this article and this part 3 may only be invested in those types of investments which are permitted by law for the investment of the assets of life insurance companies and in such other types of investments as the commissioner may permit; notwithstanding any condition, restriction, or exclusion set forth in sections 10-3-218 and 10-3-220, any asset used for a home office building or for rental to others held on May 13, 1981, by a company subject to the provisions of this article shall remain an admitted asset under part 2 of article 3 of this title so long as such company's home office is located in such asset. The provisions of section 10-3-233 shall not apply to such corporation.

Source: L. 92: Entire article R&RE, p. 1693, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16-139 as it existed prior to 1992.

10-16-321. Medicare supplement benefit standards. The provisions of article 18 of this title shall apply to corporations organized pursuant to the provisions of this part 3. On and after July 1, 1983, no corporation subject to the provisions of part 1 of this article and this part 3 shall deliver or issue for delivery in this state any subscription certificate or membership certificate intended as a medicare supplement policy, as defined in section 10-18-101, or any endorsement, rider, or application which becomes a part thereof, until a copy of the form and of the premium rates or dues pertaining thereto have been filed with the commissioner, nor shall any such certificate endorsement, rider, or application be used until the expiration of thirty days after the filing thereof, unless the commissioner sooner gives written approval thereto and of the premium rates or dues pertaining thereto. Within thirty days of such filing the commissioner shall notify the corporation which has filed any such form in writing if the documents do not comply with the requirements of law or if the rates do not meet the loss ratio standards set forth in section 10-18-105, and shall specify the reasons for such opinion. In all other cases, the commissioner shall give approval. Final orders and decisions of the commissioner relating to medicare supplement policies and rates filed under this section are subject to judicial review as provided in section 24-4-106, C.R.S. All medicare supplement policies, subscription certificates, and benefit forms and the premium rates or dues pertaining thereto which were approved by the commissioner prior to July 1, 1983, shall remain approved under the provisions of this article.

Source: L. 92: Entire article R&RE, p. 1693, § 1, effective July 1. **L. 94:** Entire section amended, p. 1649, § 91, effective May 31.

Editor's note: This section is similar to former § 10-16-140 as it existed prior to 1992.

10-16-322. Filing of health policies. Nonprofit hospital and health service corporations shall be subject to the requirements regarding the filing of health policies pursuant to section 10-16-107.2.

Source: L. 92: Entire section added, p. 1747, § 7, effective June 2.

Editor's note: Although the effective date of the repeal and reenactment of this article was July 1, 1992, this section was added, effective June 2, 1992.

10-16-323. Conversion of corporation to mutual insurance company. (Repealed)

Source: L. 94: Entire section added, p. 598, § 6, effective April 7. **L. 96:** Entire section repealed, p. 1866, § 2, effective June 6.

10-16-324. Conversion of corporation to a stock insurance company. (1) It is the intent of the general assembly by the enactment of this section to create a procedure for nonprofit hospital, medical-surgical, and health service corporations subject to the provisions of part 1 of this article and this part 3 to elect to convert to a stock insurance company subject to article 3 of this title. The general assembly in so doing recognizes the substantial and recent changes in market and health-care conditions that are affecting such corporations and further recognizes the need for equal regulatory treatment and competitive equality for health-care insurers. The general assembly further finds that a procedure for conversion to a stock insurance company will be in the best interests of policyholders by providing greater financial stability for such company's policyholders and a greater opportunity to remain a financially independent Colorado company.

(2) Any nonprofit hospital, medical-surgical, and health service corporation, referred to in this section as "corporation", subject to the provisions of part 1 of this article and this part 3 may convert, without reincorporation, to a stock insurance company subject to article 3 of this title under a plan that complies with this section and has been approved by the commissioner pursuant to this section.

(3) In order to convert to a stock insurance company, the corporation shall file with the commissioner a plan for such conversion and apply for an amended certificate of authority pursuant to part 1 of article 3 of this title. The plan shall be available to the public for inspection both at the office of the commissioner and at the office of the proponent of the plan.

(4) The plan shall set forth with specificity the terms and conditions of the proposed conversion and shall do all of the following:

(a) Certify that the plan has been adopted by a majority vote of the board of directors of the corporation;

(b) Establish that the plan and the proposed conversion will not be prejudicial to the subscribers of the corporation or the citizens of the state of Colorado;

(c) Provide a comparative premium rate analysis of the corporation's major plans and product offerings, comparing actual premium rates for the three-year period prior to the filing of the plan and projected premium rates for the three-year period following any proposed conversion. Any such rate analysis shall address the projected impact, if any, of the proposed conversion upon the cost to subscribers as well as the projected impact, if any, of the proposed conversion upon the corporation's underwriting profit, investment income, and loss and claim reserves, including the effect, if any, of adverse market or risk selection upon such reserves.

(d) Provide for the protection of all existing contractual rights of the corporation's subscribers or contract holders for medical and hospital service or claims for reimbursement thereof;

(e) (I) Specify a reasonable treatment for the benefit of the citizens of the state of Colorado of the value of the corporation on all of the following terms that must be approved by the commissioner:

(A) Such treatment shall be deemed to be reasonable if consideration, determined by the commissioner to be equal to the fair market value of the corporation, is conveyed or issued to one or more qualifying entities;

(B) The commissioner shall determine the fair market value of the corporation at the time of conversion, determined as if it had voting stock outstanding and one hundred percent of its stock were freely transferable and available for purchase without restrictions. Consideration shall be given to market value, investment or earnings value, net asset value, and a control premium, if any. If a qualifying entity or entities receive, at the time of conversion, one hundred percent of the shares of the then-outstanding stock of the corporation, the qualifying entity or entities shall be regarded as having acquired the fair market value of the corporation, unless the commissioner finds that such outstanding stock does not represent the fair market value of the corporation.

(C) Nothing contained in sub-subparagraphs (A) and (B) of this subparagraph (I) shall require the auction, sale, or marketing of the corporation or require the commissioner to fix a dollar valuation of the corporation at the time of conversion;

(D) During the first three years after conversion, to avoid dilution of the value of the qualifying entity's ownership of stock, the corporation or its affiliates may not issue stock greater in seniority, including voting rights, or dividends, than the stock, if any, initially transferred to the qualifying entity. The commissioner may waive the requirements of this sub-subparagraph (D) regarding voting rights, if the commissioner determines that the corporation has transferred to the qualifying entity or entities a benefit equivalent to such voting rights.

(E) Each qualifying entity, its directors, officers, and staff shall be and remain independent of the converted stock insurance company and its affiliates and no person who is an officer, director, or staff member of the corporation at the time the plan is submitted or at the time of conversion or thereafter shall be qualified to be an officer, director, or staff member of the qualifying entity. Nothing in this sub-subparagraph (E) shall prohibit a single member of the board of each qualifying entity, selected by such qualifying entity, from serving on the board of the corporation or the board of a holding company that owns the corporation. No director, officer, agent, or employee of the corporation shall benefit directly or indirectly from the conversion of the corporation.

(F) The charitable mission and grant-making functions of each qualifying entity must be dedicated to promoting or serving the health-care needs of the citizens of Colorado; except that in no event shall any qualifying entity use the consideration, or any proceeds or gains thereon, transferred to it by the corporation to compete directly as a licensed carrier with the corporation or any of its affiliates;

(G) The commissioner may permit all or a portion of the consideration conveyed to any qualifying entity to consist of stock of the corporation or a holding company which owns the corporation. Stock transferred to a qualifying entity may be restricted as set out in the plan approved by the commissioner.

(H) Repealed.

(I) At the time of the conversion, the corporation or a holding company that owns the corporation may issue additional voting shares of stock through an initial public offering or private placement, which stock shall not be included in the consideration transferred to a qualifying entity.

(II) (A) For purposes of this paragraph (e), a "qualifying entity" means an independent tax-exempt charitable or social welfare organization, operating under sections 501(c)(3) or 501(c)(4) of title 26 of the United States Code, the federal "Internal Revenue Code of 1986", as amended.

(B) Whether the qualifying entity is organized under said sections 501 (c)(3) or 501 (c)(4) of the federal "Internal Revenue Code of 1986", as amended, the articles of incorporation of the qualifying entity shall contain at least the following provisions: The qualifying entity shall be organized and operated exclusively for charitable, educational, or scientific purposes consistent with sub-subparagraph (F) of subparagraph (I) of this paragraph (e); the qualifying entity shall engage in lobbying or political activities only to the extent permitted an organization exempt under section 501 (c)(3) of the internal revenue code; the qualifying entity shall not engage in campaign activity or the making of political contributions; no part of the net earnings of the qualified entity may inure to the benefit of any individual; the qualifying entity may not engage in any self dealing for the benefit of its directors, officers, or employees; the qualifying entity shall report to the public at least annually information equivalent to that required of organizations qualified under section 501 (c)(3) of the federal "Internal Revenue Code of 1986", as amended. Nothing in this sub-subparagraph (B), however, shall require that a qualified entity divest itself of stock of the corporation.

(C) A "qualifying entity" shall be newly established for purposes of the conversion authorized in this section, unless otherwise approved by the commissioner.

(f) Specify the proposed amendments to the corporation's articles of incorporation, bylaws, and other documents of organization to effectuate the conversion;

(g) Specify the proposed form of notice of the proposed conversion to be published as set forth in subsection (6) of this section; and

(h) Provide such other information as determined by the commissioner to be reasonably necessary and relevant to the evaluation of the plan.

(5) The commissioner may retain, upon notice to the corporation, any qualified expert, such as attorneys, accountants, actuaries, and financial analysts, not otherwise a part of the commissioner's staff, to assist in reviewing the proposed plan, with such reasonable expenses incurred during the review to be borne by the corporation.

(6) Within thirty days after filing the plan of conversion and application for an amended certificate of authority, the corporation shall:

(a) Publish notice, in a form and in newspapers to be approved by the commissioner, of the proposed plan of conversion once a week for three consecutive weeks in at least one daily newspaper of general circulation in the counties in which the corporation does business;

(b) Cause notice, in a form and manner to be approved by the commissioner, of the proposed plan of conversion to be delivered by regular mail to all current subscribers; and

(c) Submit to the commissioner proof of publication of the notice required by paragraph (a) of this subsection (6) and properly executed amendments to the corporation's articles of

incorporation, bylaws, and other organizational documents to effectuate the conversion authorized by this section.

(7) The commissioner shall hold a hearing pursuant to article 4 of title 24, C.R.S., before making a final decision to approve or disapprove the plan of conversion within sixty days after completion of publication of notice of the hearing thereon. The commissioner shall issue an order approving or disapproving the plan or approving an amended plan within sixty days after completion of the hearing.

(8) Upon mutual agreement of the corporation and the commissioner, the commissioner may enter an order extending any time limits within this section.

(9) The commissioner shall approve the plan of conversion if the commissioner finds that:

(a) The plan meets the requirements of subsection (4) of this section;

(b) The plan is fair and reasonable and not contrary to law or to the interests of subscribers, contract holders, or the public; and

(c) Upon conversion, the corporation will meet the standards and conditions applicable to stock insurance companies, including minimum surplus required of such companies.

(10) The conversion shall become effective as specified in the plan of conversion and when the revised articles of incorporation have been adopted.

(11) The corporate existence of the corporation shall not terminate upon conversion as provided for in this section, but the converted stock company shall be deemed to be a continuation of the corporation and to have been organized on the date the corporation was originally organized. Conversion under this section will not cause a dissolution of the corporation.

(12) Except as specifically provided for in this section, upon completion of its conversion to a stock insurance company as provided in this section, the corporation shall no longer be subject to this article and shall be subject to and comply with all laws and regulations applicable to a stock insurance company as provided in article 3 of this title, including all other requirements of a stock insurer as contained in this title.

(13) In the year of conversion, the corporation shall be obligated to pay the subscriber fee provided in section 10-16-110 (1)(c) for the portion of the year before the effective date of the conversion and premium taxes as a stock insurer pursuant to section 10-3-209 for premiums collected or contracted for the portion of the year from and including the effective date of the conversion.

(14) The converted stock insurance company shall be a member insurer under the "Life and Health Insurance Protection Association Act" as provided by article 20 of this title. All subscribers of the corporation existing on the date of conversion will be afforded coverage and protection in accordance with the terms and conditions of the said act. The converted stock insurance company will be subject to assessments as provided in article 20 of this title, and its share of any class B assessment made under section 10-20-109 (3)(b) shall be calculated, as applicable, based upon any Colorado premium or subscriber fees received by it during the calendar years immediately preceding its conversion to a stock insurance company; except that nothing in this subsection (14) shall require the converted stock insurance company to be assessed for insolvencies relating to member insurers who became insolvent insurers prior to the effective date of the conversion.

(15) Any final action by the commissioner pursuant to subsection (7) of this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S., at the initiation of the corporation seeking conversion to a newly created stock insurance company, or any person that was a party to the agency proceeding and was adversely affected or aggrieved by the final agency decision. The remedies set forth in this subsection (15) are exclusive remedies for any person aggrieved by a final action of the commissioner under this section.

Source: L. 96: Entire section added, p. 1861, § 1, effective June 6. **L. 99:** (4)(e)(I)(H) repealed, p. 1005, § 1, effective May 29. **L. 2013:** (4)(e)(I)(F) amended, (HB 13-1266), ch. 217, p. 988, § 50, effective May 13.

10-16-325. Termination of health policies. A corporation shall not retroactively terminate a policy issued pursuant to this part 3 except for fraud or intentional misrepresentation. For any termination other than for fraud or intentional misrepresentation, the corporation shall provide notice thirty days in advance of the cancellation of the policy.

Source: L. 2013: Entire section added, (HB 13-1266), ch. 217, p. 980, § 32, effective May 13.

PART 4

HEALTH MAINTENANCE ORGANIZATIONS

10-16-401. Establishment of health maintenance organizations. (1) The general assembly recognizes that health-care coverage may be offered to the citizens of this state by various entities with distinct organizational and functional forms. The placement of this part 4 in this article should in no way be construed so as to alter the distinct organizational and functional character of health maintenance organizations or to alter the legal distinctions between such organizations and other health-care coverage entities.

(2) Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with part 1 of this article and this part 4; however, the general assembly declares that nothing in part 1 of this article or this part 4 shall be construed to ensure the success of any health maintenance organization and the state accepts no responsibility for the financial obligations of such organizations. No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under this part 4. A foreign corporation may qualify under this part 4 subject to its registration to do business in this state as a foreign corporation.

(3) Every health maintenance organization as of July 6, 1973, shall submit an application for a certificate of authority under subsection (4) of this section within one hundred eighty days of the said date. Each such applicant may continue to operate until the commissioner acts upon the application. In the event that an application is denied under section 10-16-402, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

(4) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(a) A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto, in triplicate, for examination by the commissioner and attorney general. Where required, said articles shall be filed and recorded in the office of the secretary of state who shall issue a certificate of incorporation. A copy of such articles shall be filed with the commissioner.

(b) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(c) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(d) A copy of any contract made or to be made between any providers or persons listed in paragraph (c) of this subsection (4) and the applicant;

(e) A statement generally describing the health maintenance organization, its health-care plan or plans, facilities, and personnel;

(f) A copy of the form of evidence of coverage to be issued to the enrollees;

(g) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(h) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of part 1 of this article and this part 4.

(i) A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding;

(j) A power of attorney duly executed by such applicant, if not domiciled in this state, appointing the commissioner and the commissioner's successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(k) A statement reasonably describing the geographic area or areas to be served;

(l) A description of the complaint procedures to be utilized as required under section 10-16-409;

(m) A description of the procedures and programs to be implemented to meet the quality of health-care requirements in section 10-16-402 (1)(b);

(n) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 10-16-404 (2);

(o) Such other information as the commissioner may require to make the determinations required in section 10-16-402;

(p) An access plan for each separate network of the health maintenance organization as specified in section 10-16-704 (9). To the extent that the information in the access plan contains the required information specified in paragraphs (e), (f), (k), (l), (m), and (n) of this subsection (4), the health maintenance organization shall be deemed to be in compliance with said paragraphs.

(5) A health maintenance organization shall, unless otherwise provided for in part 1 of this article or this part 4, file a notice describing any modification of the operation set out in the information required by subsection (4) of this section. Such notice shall be filed with the commissioner prior to the modification. If the commissioner does not disapprove within thirty days of filing, such modification shall be deemed approved.

Source: L. 92: Entire article R&RE, p. 1694, §1, effective July 1; (4)(a) amended, p. 1599,§ 123, effective July 1. **L. 97:** (4)(p) added, p. 1332, § 3, effective July 1.

Editor's note: This section is similar to former § 10-17-103 as it existed prior to 1992.

10-16-402. Issuance of certificate of authority - denial.

(1) (a) Repealed.

(b) The commissioner shall determine whether the applicant for a certificate of authority, with respect to health-care services to be furnished:

(I) Has demonstrated the willingness and potential ability to assure that such health-care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility, and continuity of service;

(II) Has arrangements, established in accordance with regulations promulgated by the commissioner, for an ongoing quality of health care assurance program concerning health-care processes and outcomes; and

(III) Has a procedure, established in accordance with regulations of the commissioner, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required by the commissioner.

(c) Repealed.

(2) The commissioner shall issue a certificate of authority upon payment of the application fee prescribed in section 10-16-110 (2) if the commissioner is satisfied that the following conditions are met:

(a) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(b) The commissioner determines in accordance with subsection (1) of this section that the health maintenance organization's proposed plan of operation meets the requirements of subsection (1)(b) of this section;

(c) (I) The health maintenance organization will effectively provide or arrange for the provision of basic health-care services, through insurance or otherwise, except to the extent of

reasonable requirements for copayments, deductibles, and payments for out-of-network services received pursuant to section 10-16-704 (2).

(II) Nothing in this paragraph (c) shall prohibit a carrier from offering to a small employer additional options of a health benefit plan that:

(A) Provides for different benefits for insureds and dependents of insureds covered by the same policy; and

(B) Encourages appropriate health-care condition management based on clinical guidelines by providing case management benefits to covered persons.

(d) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(I) The financial soundness of the health-care plan's arrangements for health-care services and the schedule of charges used in connection therewith;

(II) The adequacy of working capital;

(III) Any agreement with an insurer, a nonprofit hospital, medical-surgical, and health service corporation, a government, or any other organization for insuring the payment of the cost of health-care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

(IV) Any agreement with providers for the provision of health-care services;

(V) Any surety bond or deposit of cash or securities submitted in accordance with section 10-16-412 as a guarantee that the obligations will be duly performed.

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to section 10-16-404;

(f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 10-16-401 or by independent investigation, is contrary to the public interest;

(g) Any deficiencies certified by the commissioner have been corrected.

(3) A certificate of authority shall be denied only after compliance with the requirements of section 10-16-419.

(4) A certificate of authority shall expire on the last day of June in each year and shall be renewed annually if the company has continued to comply with the laws of this state.

Source: L. 92: Entire article R&RE, p. 1696, § 1, effective July 1; (4) added, p. 1599, § 124, effective July 1. **L. 93:** (2)(d)(V) amended, p. 1772, § 26, effective June 6. **L. 2002:** (2)(c) amended, p. 1296, § 11, effective January 1, 2003. **L. 2003:** (2)(c) amended, p. 1778, § 13, effective January 1, 2004. **L. 2006:** (2)(c)(I) amended, p. 1491, § 16, effective June 1. **L. 2017:** (1)(a) and (1)(c) repealed and IP(1)(b), (1)(b)(II), (1)(b)(III), IP(2), (2)(b), and (2)(g) amended, (SB 17-249), ch. 283, p. 1545, § 7, effective June 1.

Editor's note: This section is similar to former § 10-17-104 as it existed prior to 1992.

10-16-403. Powers of health maintenance organizations. (1) The powers of a health maintenance organization include, but are not limited to, the following:

(a) The purchase, lease, construction, renovation, operation, and maintenance of hospitals, medical facilities, nursing care and intermediate care facilities, and other institutions of like nature, their ancillary equipment, and such property as may reasonably be required for its

administrative offices or for such other purposes as may be necessary to accomplish the business of the organization;

(b) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities, hospitals, nursing care and intermediate care facilities, and other institutions of a like nature providing health-care services to enrollees;

(c) The furnishing of health-care services through providers which are under contract with or employed by the health maintenance organization;

(d) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;

(e) The contracting with an insurance company licensed in this state, or with a nonprofit hospital, medical-surgical, and health service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health-care services provided by the health maintenance organization;

(f) The offering, in addition to basic health-care services, of:

(I) Additional health-care services;

(II) Indemnity benefits not exceeding twenty percent of net medical and hospital expenses incurred on an annual basis;

(III) Indemnity benefits, in addition to benefits provided directly or indirectly through contracts with providers, by the health maintenance organization, through insurers or nonprofit hospital, medical-surgical, and health service corporations;

(g) The offering of contracts for the rendering of long-term care insurance, as defined in section 10-19-103 (5), on behalf of any of its enrollees. Such contracts shall comply with article 19 of this title.

(h) Repealed.

(2) (a) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in the introductory portion or paragraph (a) of subsection (1) of this section. The commissioner shall disapprove such exercise of power, if in the commissioner's opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove within thirty days of the filing, it shall be deemed approved.

(b) The commissioner may promulgate rules and regulations exempting from the filing requirement of paragraph (a) of this subsection (2) those activities having a de minimis effect.

Source: L. 92: Entire article R&RE, p. 1698, § 1, effective July 1. **L. 94:** (1)(a) and (1)(b) amended, p. 1629, § 27, effective May 31. **L. 99:** (1)(f) amended, p. 80, § 1, effective July 1. **L. 2009:** (1)(h) added, (HB 09-1143), ch. 114, p. 479, § 2, effective August 5.

Editor's note: (1) This section is similar to former § 10-17-105 as it existed prior to 1992.

(2) Subsection (1)(h) provided for the repeal of subsection (1)(h), effective July 1, 2012. (See L. 2009, p. 479.)

Cross references: For the legislative declaration contained in the 2009 act adding subsection (1)(h), see section 1 of chapter 114, Session Laws of Colorado 2009.

10-16-404. Governing body. (1) The governing body of any health maintenance organization may include providers, other individuals, or both.

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

Source: L. 92: Entire article R&RE, p. 1700, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-106 as it existed prior to 1992.

10-16-405. Fiduciary responsibilities. Any director, officer, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees.

Source: L. 92: Entire article R&RE, p. 1700, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-107 as it existed prior to 1992.

10-16-406. Evidence of coverage - rules. (1) Every enrollee residing in this state is entitled to evidence of coverage under a health-care plan. If the enrollee obtains coverage under a health-care plan through an insurance policy or a contract issued by a nonprofit hospital, medical-surgical, and health service corporation, whether by option or otherwise, the insurer or the nonprofit hospital, medical-surgical, and health service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(2) (a) The commissioner may establish, by rule, the required elements of an evidence of coverage, which must:

(I) Not contain any provisions or statements that are unjust, unfair, inequitable, misleading, or deceptive; encourage misrepresentation; or are untrue, misleading, or deceptive as defined in section 10-16-413 (1); and

(II) Contain a clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

(A) The health-care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health-care plan, including the ability to obtain a second opinion for proposed treatment by the health-care provider, if the health benefit plan provides such coverage;

(B) Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or copayment feature;

(C) Where and in what manner information is available as to how services may be obtained;

(D) The total amount of payment for health-care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;

(E) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

(b) The carrier may evidence a subsequent change in coverage in a separate document issued to the enrollee.

(c) A copy of the form of the evidence of coverage to be used in this state, and any amendment to the form, is subject to the filing and approval requirements of section 10-16-107.2.

Source: L. 92: Entire article R&RE, p. 1700, § 1, effective July 1. **L. 2013:** Entire section amended with relocations, (HB 13-1266), ch. 217, p. 980, § 33, effective May 13.

Editor's note: (1) This section is similar to former § 10-17-108 as it existed prior to 1992.

(2) Subsection (2) is similar to § 10-16-107 (3)(b), (3)(c), and (3)(d) as they existed prior to 2013.

10-16-407. Information to enrollees. (1) Every health maintenance organization shall annually provide to its enrollees:

(a) The most recent annual statement of financial condition including a balance sheet and summary of receipts and disbursements;

(b) A description of the organizational structure and operation of the health care plan and a summary of any material changes since the issuance of the last report;

(c) A description of services and information as to where and how to secure them; and

(d) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

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

(3) (a) A health maintenance organization that offers basic health-care services to enrollees through a limited health benefit plan pursuant to section 10-16-403 (1)(h) shall clearly state in its brochures, contracts, policy manuals, and printed materials distributed to enrollees the following information:

(I) That a limited health benefit plan may impose a limit on the total maximum benefit amount available to the enrollee on an annual basis and on the total maximum benefit amounts available for particular health-care services provided during a given year;

(II) The specific amount of the annual total maximum benefit amount and the annual total maximum amount for particular health-care services covered by the limited health benefit plan; and

(III) That once the enrollee receives the total maximum amount of benefits under the limited health benefit plan in any given year, or receives the total maximum amount of benefits for a particular health-care service in a given year, the enrollee is responsible for paying out-of-pocket for the costs of any health-care services provided to the enrollee during that year that exceed the total annual maximum benefit amount or the total maximum benefit amount for a particular health-care service, as applicable.

(b) The health maintenance organization shall ensure that the information required by this subsection (3) is prominently displayed, in bold-faced font in at least fourteen-point type, on any materials provided to enrollees.

(c) (I) Each enrollee who participates in a limited health benefit plan shall sign the following statement of understanding indicating his or her understanding of the limitations of the plan:

STATEMENT OF UNDERSTANDING

I, _____, understand that I am enrolling in a limited health benefit plan that contains a total maximum annual amount of benefits available to me and my covered dependents each plan year for basic health care services. The total maximum annual benefit amount is ____.

I understand that once I receive the total maximum amount of benefits under the limited health benefit plan in a plan year, I am fully responsible for paying out-of-pocket for the costs or charges for any health care services I or my covered dependents receive during the remaining portion of the plan year.

I understand that I may exhaust my total annual maximum benefit amount while I am or a covered dependent is undergoing treatment for an illness or injury and that I will be responsible for paying the costs of treatment provided after I have exhausted my benefits under the limited health benefit plan.

I understand that if I exhaust my total annual maximum benefit amount in a plan year, I or my covered dependent may or may not be eligible for the state Medicaid program or other public programs and that it is solely my choice and responsibility to investigate my options and eligibility for participation in any public program.

_____ _____

Signature of Enrollee **Date**

(II) The health maintenance organization shall retain the original, signed statement of understanding, shall provide a copy to the enrollee, and shall make the statement available to the commissioner upon request.

Source: L. 92: Entire article R&RE, p. 1700, § 1, effective July 1; (2) added, p. 1789, § 1, effective January 1, 1993. **L. 2002:** (2) amended, p. 1295, § 10, effective January 1, 2003. **L.**

2009: (3) added, (HB 09-1143), ch. 114, p. 481, § 3, effective August 5. **L. 2024:** (3)(c)(I) amended, (HB 24-1399), ch. 76, p. 254, § 10, effective July 1, 2025.

Editor's note: (1) This section is similar to former § 10-17-110 as it existed prior to 1992.

(2) Subsection (2) of this section was numbered as § 10-17-110 (2) in Senate Bill 92-104 but was renumbered on revision and harmonized with this section since article 17 was repealed and the substantive provisions of § 10-17-110 were moved to this section.

Cross references: For the legislative declaration contained in the 2009 act adding subsection (3), see section 1 of chapter 114, Session Laws of Colorado 2009.

10-16-408. Open enrollment. (1) After a health maintenance organization has been in operation twenty-four months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. A health maintenance organization may apply to the commissioner for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health-care services. The commissioner shall approve or deny such application within thirty days of the receipt thereof from the health maintenance organization.

(2) Health maintenance organizations providing or arranging for services exclusively on a group contract basis may limit the open enrollment provided for in subsection (1) of this section to all members of the group or groups covered by such contracts.

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

Source: L. 92: Entire article R&RE, p. 1701, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-111 as it existed prior to 1992.

10-16-409. Complaint system. (1) (a) Every health maintenance organization shall establish and maintain a complaint system that has been approved by the commissioner to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health-care services.

(b) Each health maintenance organization shall maintain written records relating to its complaint system in a form prescribed by the commissioner, for examination by the commissioner, which form must include:

(I) A description of the procedures of such complaint system;

(II) The total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed;

(III) The number, amount, and disposition of malpractice claims settled during the year by the health maintenance organization and any of the providers used by it which involve services covered by the health maintenance organization.

(2) The health maintenance organization shall maintain records of written complaints filed with it concerning other than health-care services and shall submit to the commissioner a summary report at such times and in such format as the commissioner may require. Such complaints involving other persons shall be referred to such persons with a copy to the commissioner.

(3) The commissioner may examine the complaint system required by subsection (1) of this section, subject to the limitations concerning medical records of individuals set forth in section 10-16-416 (3).

Source: L. 92: Entire article R&RE, p. 1701, § 1, effective July 1. **L. 2017:** (1)(a), IP(1)(b), and (3) amended, (SB 17-249), ch. 283, p. 1545, § 8, effective June 1.

Editor's note: This section is similar to former § 10-17-112 as it existed prior to 1992.

10-16-410. Investments. With the exception of investments made in accordance with section 10-16-403 (1)(a) and (2), the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this state for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner may permit.

Source: L. 92: Entire article R&RE, p. 1702, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-113 as it existed prior to 1992.

10-16-411. Protection against insolvency. (1) (a) Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial minimum surplus of one million five hundred thousand dollars. "Surplus" means total assets less all liabilities with the exception of long-term loans from the secretary of the United States department of health and human services or other loan or obligation with terms and conditions acceptable to the commissioner. Such loan or obligation shall be considered equity until such time as the funding source shall declare that repayment shall commence. Upon such declaration, the amount necessary to fund the repayments, including accrued interest thereon, for the ensuing twelve months will be included as a direct liability and so classified in the determination of minimum surplus as provided by this subsection (1).

(a.5) The minimum surplus required by paragraph (a) of this subsection (1) may be reduced by up to five hundred thousand dollars if the health maintenance organization has available to it an administrative infrastructure that the commissioner considers appropriate to reduce, control, or eliminate start-up costs associated with the administration of the health maintenance organization. Such infrastructure includes office space and equipment, computer systems, software, management services contract, and personnel recruitment fees.

(b) Every health maintenance organization shall maintain a minimum surplus at least equal to one million dollars.

(c) and (d) (Deleted by amendment, L. 99, p. 80, § 2, effective July 1, 1999.)

(1.5) (a) Notwithstanding any provision of subsection (2) or (4) of this section to the contrary, a health maintenance organization whose sole business is providing health-care services to recipients under the "Colorado Medical Assistance Act", articles 4 to 6 of title 25.5, C.R.S., the children's basic health plan, article 8 of title 25.5, C.R.S., or medicare under Title XVIII of the federal "Social Security Act", as amended, shall maintain a minimum surplus of not less than four million dollars and shall maintain a claims liability within its financial statement equal to the greater of:

(I) One month of federal and state reimbursements received by the health maintenance organization for services provided to health-care recipients; or

(II) The health maintenance organization's total outstanding claims liabilities.

(b) A health maintenance organization subject to this subsection (1.5) annually shall submit an opinion by a qualified actuary that attests that the health maintenance organization's surplus level and outstanding claims liability meet the requirements of this subsection (1.5).

(2) The commissioner may, by rule, establish standards consistent with the risk-based capital models applicable to managed care organizations developed or adopted by the national association of insurance commissioners that require any such corporation to maintain a greater minimum level of surplus than the specified dollar minimums established by subsection (1) of this section. Such minimum level of surplus shall reflect the type, volume, and nature of the business being transacted. Such rules may additionally require the submission of an opinion by a qualified actuary that states whether or not the surplus level of the entity is sufficient.

(3) If a health maintenance organization fails to comply with the surplus requirements of this section, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be detrimental to its enrollees.

(4) (a) If the initial application of this section would cause a reduction in the total capital and surplus of a health maintenance organization of ten percent or more or would cause the capital and surplus of a health maintenance organization to fall to or below the company action level as defined by the commissioner by rule, such health maintenance organization may, within thirty days after the effective date of such rule, file with the commissioner a request to phase in the requirements of this section over a period not to exceed three years or another time period as approved by the commissioner.

(b) Any request made pursuant to paragraph (a) of this subsection (4) shall include a complete analysis, in a form prescribed by the commissioner, of the impact upon the health maintenance organization making the request, that is expected to result from application of this section and, if a phase-in is requested, a description of the health maintenance organization's plan for the phase-in period. The commissioner shall not deny a request for a phase-in except upon notice and an opportunity for a hearing as provided in section 24-4-105, C.R.S.

(c) Any request for a hearing made pursuant to paragraph (b) of this subsection (4) shall include a description of the basis upon which relief is sought. Upon receipt of such a request, the commissioner shall, with regard to the health maintenance organization making the request, postpone the effective date of the section pending the conclusion of the hearing and the taking of final agency action thereon. The hearing shall commence within sixty days after the

commissioner receives the request and shall be conducted in accordance with section 24-4-105, C.R.S.

Source: L. 92: Entire article R&RE, p. 1702, § 1, effective July 1. **L. 99:** Entire section amended, p. 80, § 2, effective July 1. **L. 2007:** (1.5) added, p. 1355, § 5, effective May 29.

Editor's note: This section is similar to former § 10-17-114 as it existed prior to 1992.

10-16-412. Statutory deposit. (1) Unless otherwise provided in subsections (2) and (3) of this section, each health maintenance organization shall furnish cash or securities acceptable to the commissioner to be held by the commissioner under joint control in the same manner as prescribed in sections 10-3-206, 10-3-210, and 10-3-211. The primary purpose of this deposit shall be to protect the interests of the enrollees and to assure continuation of health-care services to enrollees of a health maintenance organization and to cover reasonable administration costs attributed to rehabilitation, liquidation, or conservation under section 10-16-418.

(2) (a) Every health maintenance organization shall have an initial deposit of three hundred thousand dollars.

(b) (Deleted by amendment, L. 99, p. 83, § 3, effective July 1, 1999.)

(3) Health maintenance organizations shall establish and maintain the following minimum deposits:

(a) The following schedule, based upon enrollment levels achieved on December 31 of the preceding year:

(I) to (III) (Deleted by amendment, L. 99, p. 83, § 3, effective July 1, 1999.)

(IV) $300,000: Enrollment of less than 60,000;

(V) $350,000: Enrollment of 60,000 but less than 100,000;

(VI) $400,000: Enrollment of 100,000 or more.

(b) The statutory deposit shall at all times equal or exceed twenty-five percent of the health maintenance organization's uncovered expenditures for the previous calendar year. At such time as the deposit is less than twenty-five percent of the health maintenance organization's uncovered expenditures for the previous calendar year, additional deposits will be required to maintain this level. The maximum deposit required, however, shall not exceed one million dollars.

(4) (a) If the initial application of this section would create undue financial risks to the enrollees of a health maintenance organization, such health maintenance organization may, within thirty days after July 1, 1999, file with the commissioner a request to phase in the requirements of this section over a period not to exceed three years or another time period as approved by the commissioner.

(b) Any request made pursuant to paragraph (a) of this subsection (4) shall include a complete analysis, in a form prescribed by the commissioner, of the impact upon the health maintenance organization making the request, that is expected to result from application of this section and, if a phase-in is requested, a description of the health maintenance organization's plan for the phase-in period. The commissioner shall not deny a request for a phase-in except upon notice and an opportunity for a hearing as provided in section 24-4-105, C.R.S.

(c) Any request for a hearing made pursuant to paragraph (b) of this subsection (4) shall include a description of the basis upon which relief is sought. Upon receipt of such a request, the

commissioner shall, with regard to the health maintenance organization making the request, postpone the effective date of the section pending the conclusion of the hearing and the taking of final agency action thereon. The hearing shall commence within sixty days after the commissioner receives the request and shall be conducted in accordance with section 24-4-105, C.R.S.

Source: L. 92: Entire article R&RE, p. 1704, § 1, effective July 1. **L. 99:** (2) and (3) amended and (4) added, p. 83, § 3, effective July 1. **L. 2019:** (3)(a)(IV) amended, (HB 19-1291), ch. 188, p. 2094, § 5, effective August 2.

Editor's note: This section is similar to former § 10-17-114.5 as it existed prior to 1992.

10-16-413. Prohibited practices. (1) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of part 1 of this article and this part 4:

(a) A statement or item of information is deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health-care plan.

(b) A statement or item of information is deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person not possessing special knowledge regarding health-care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health-care plan, if such benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist.

(c) An evidence of coverage is deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health-care plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health-care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

(2) Part 11 of article 3 of this title shall apply to health maintenance organizations, health-care plans, and evidences of coverage except to the extent that the commissioner determines that the nature of health maintenance organizations, health-care plans, and evidences of coverage render such article clearly inapplicable.

(3) An enrollee may not be canceled or nonrenewed on the basis of the status of such enrollee's health.

(4) No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature any of the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business and shall be distinguishable on the records of the secretary of state from the name or description of any insurance or surety corporation doing business in this state.

Source: L. 92: Entire article R&RE, p. 1705, § 1, effective July 1. **L. 2000:** (4) amended, p. 988, § 104, effective July 1.

Editor's note: This section is similar to former § 10-17-115 as it existed prior to 1992.

10-16-413.5. Return to home - legislative declaration - definitions. (1) The general assembly hereby finds that:

(a) As individuals "age in place" in their own homes or other settings, they frequently contract with continuing care retirement communities, assisted living facilities, nursing facilities, or facilities for persons with dementia diseases and related disabilities to receive the services they need in order to maximize their independence;

(b) Elderly individuals and individuals with disabilities select particular facilities because of proximity to family and friends, religious affiliation, reputation in the community, or the security offered in a particular setting;

(c) Some health-care service plan contracts require that an enrollee be placed in a skilled nursing facility participating in the plan;

(d) Requiring an elderly individual or an individual with a disability to move into an unfamiliar environment can be traumatic and have an adverse effect on the person's psychological, social, and physical well-being;

(e) Elderly individuals and individuals with disabilities who require hospitalization need to be able to "return to home" without interference from health-care coverage providers, if the facility is able to provide the needed services and is willing to accept payment on the same terms as a network provider.

(2) As used in this section, unless the context otherwise requires:

(a) "Continuing care" means furnishing, pursuant to an agreement, shelter, food, and either nursing care or personal services whether such nursing care or personal services are provided in a facility or another setting designated by the agreement for continuing care, nursing care, or personal care services, to an individual not related by consanguinity or affinity to the provider furnishing care upon payment of an entrance or rental fee.

(b) "Enrollee" means an individual who is eligible for health-care benefits under a contract with a carrier.

(3) On and after January 1, 2000, no carrier, including a carrier that offers a medicare supplement policy pursuant to article 18 of this title, shall deny payment for continuing care provided to an enrollee even if the provider is not under contract with the carrier if all of the following apply:

(a) The service is a covered benefit under the terms of the contract covering the enrollee;

(b) The enrollee:

(I) Prior to being hospitalized, resided where the continuing care services are to be provided;

(II) Had a contractual or other right to return to such location; and

(III) Returned to such location regardless of whether he or she returned to a different part of a facility in which he or she resided prior to hospitalization;

(c) The level of care that the enrollee needs may be provided at the location where the continuing care services are to be provided and the location is licensed by the state of Colorado as a skilled nursing facility and certified as participating in medicare; and

(d) With respect to an enrollee returning to the location where the continuing care services are to be provided pursuant to this section, the provider of continuing care services agrees to abide by the same terms and conditions that apply to participating providers under contract with the carrier, including but not limited to:

(I) Utilization review, quality assurance, peer review, and access to health-care services; and

(II) Management and administrative procedures including data and financial reporting procedures that may be required by the carrier.

(4) The carrier shall pay the provider of continuing care services for covered benefits at the same rate for the same level and intensity of services as providers under contract with the carrier.

(5) The enrollee shall have a cause of action against the carrier for a violation of this section. The action may be commenced by the enrollee or on behalf of the enrollee by an adult relative, friend, or guardian of the enrollee who has an interest in or the responsibility for the enrollee's welfare.

Source: L. 99: Entire section added, p. 1095, § 1, effective June 1. **L. 2014:** (1)(b), (1)(d), and (1)(e) amended, (SB 14-118), ch. 250, p. 984, § 15, effective August 6. **L. 2018:** (1)(a) amended, (HB 18-1091), ch. 74, p. 644, § 9, effective August 8.

10-16-414. Regulation of agents. The commissioner may, after notice and hearing, promulgate such reasonable rules and regulations as are necessary to provide for the licensing of agents. An agent means a person directly or indirectly associated with a health-care plan who engages in solicitation or enrollment.

Source: L. 92: Entire article R&RE, p. 1706, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-116 as it existed prior to 1992.

10-16-415. Powers of insurers and nonprofit hospital, medical-surgical, and health service corporations. (1) An insurance company licensed in this state, or a nonprofit hospital, medical-surgical, and health service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of part 1 of this article and this part 4. Notwithstanding any other law which may be inconsistent, any two or more such insurance companies, nonprofit hospital, medical-surgical, and health service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. An insurance company shall not be considered in violation of the laws regulating insurance by the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any other provision of law, an insurer or a nonprofit hospital, medical-surgical, and health service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance

organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or nonprofit hospital, medical-surgical, and health service corporation may make benefit payments to health maintenance organizations for health-care services rendered by providers pursuant to contracts with health maintenance organizations.

Source: L. 92: Entire article R&RE, p. 1706, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-117 as it existed prior to 1992.

10-16-416. Examination. (1) The commissioner may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health-care plan as often as the commissioner deems it necessary for the protection of the interests of the people of this state but not less frequently than once every five years.

(2) Repealed.

(3) Every health maintenance organization and provider shall submit its books and records relating to the health-care plan to the examination required by subsection (1) of this section and shall in every way facilitate the examination. Medical records of individuals and records of physicians providing service under a contract to the health maintenance organization are not subject to the examination, although they may be subject to subpoena upon a showing of good cause. For the purpose of the examination, the commissioner may administer oaths to, and examine, the officers and agents of the health maintenance organization and the principals of its providers concerning their business.

(4) The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner.

(5) In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner or the head of the health department of another state.

(6) To supplement the examination powers of the commissioner, as provided in this section, the commissioner may request or require any foreign company, entity, or new applicant, or any domestic company may make a request to the commissioner, to be examined by independent examiners certified by the society of financial examiners, actuaries who are members of the American academy of actuaries, or other qualified loss reserve specialists, independent risk managers, independent certified public accountants, or other qualified examiners of insurance companies deemed competent by the commissioner, or any combination of such qualified persons. The commissioner may also accept, as part of the commissioner's examination, reports made by any qualified person pursuant to this subsection (6). Neither such persons nor members of their immediate families shall be officers of, connected with, or financially interested in the entity, company, or applicant being examined other than as policyholders, nor shall they be financially interested in any other corporation or person affected by the examination, investigation, or hearing. The commissioner shall establish guidelines for assuring the neutrality of those persons to be authorized to supplement the examination procedures authorized in this section. The reasonable expenses and charges of such persons so retained or designated shall be paid directly by any foreign company, entity, or new applicant or domestic company to any such outside authorized examiner.

Source: L. 92: Entire article R&RE, p. 1706, § 1, effective July 1. **L. 97:** (1) amended, p. 530, § 3, effective April 24. **L. 2017:** (2) repealed and (3), (4), and (5) amended, (SB 17-249), ch. 283, p. 1546, § 9, effective June 1.

Editor's note: This section is similar to former § 10-17-118 as it existed prior to 1992.

10-16-417. Suspension or revocation of certificate of authority. (1) The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to part 1 of this article 16 and this part 4 if the commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health-care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to section 10-16-401, unless amendments to such submissions have been filed with and approved by the commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health-care services which do not comply with the requirements of section 10-16-406;

(c) The health-care plan does not provide or arrange for basic health-care services;

(d) The commissioner determines that:

(I) The health maintenance organization does not meet the requirements of section 10-16-402 (1)(b); or

(II) The health maintenance organization is unable to fulfill its obligations to furnish health-care services as required under its health-care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation pursuant to section 10-16-404;

(g) The health maintenance organization has failed to implement the complaint system required by section 10-16-409 in a manner to reasonably resolve valid complaints;

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization has otherwise failed to substantially comply with part 1 of this article or this part 4.

(2) A certificate of authority shall be suspended or revoked only after compliance with the requirements of section 10-16-419.

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(4) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health-care coverage.

Source: L. 92: Entire article R&RE, p. 1708, § 1, effective July 1. **L. 2017:** IP(1) and (1)(d) amended, (SB 17-249), ch. 283, p. 1546, § 10, effective June 1.

Editor's note: This section is similar to former § 10-17-119 as it existed prior to 1992.

10-16-418. Rehabilitation, liquidation, or conservation of health maintenance organization. (1) Any rehabilitation, liquidation, or conservation of a health maintenance organization is deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies, except as otherwise provided in this section.

(2) A provider which has not expressly agreed to hold enrollees harmless if the provider is not paid by the health maintenance organization may elect to take the priority of a person stated in section 10-3-541 (1)(b); except that, if such election is made, the claim by such provider shall only be paid upon condition that the provider shall not assert such claim against any enrollee of the health maintenance organization.

Source: L. 92: Entire article R&RE, p. 1709, § 1, effective July 1. **L. 94:** (2) amended, p. 1630, § 28, effective May 31.

Editor's note: This section is similar to former § 10-17-120 as it existed prior to 1992.

Cross references: For provisions pertaining to the rehabilitation and liquidation of insurers, see part 5 of article 3 of this title 10.

10-16-419. Administrative procedures. (1) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the health maintenance organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least twenty days but, in the case of a denial, not more than sixty days thereafter for a hearing on the matter.

(2) After a hearing held pursuant to subsection (1) of this section or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall take action as is deemed advisable on written findings, which shall be mailed to the health maintenance organization.

(3) The provisions of article 4 of title 24, C.R.S., shall apply to proceedings under this section to the extent they are not in conflict with subsections (1) and (2) of this section, and any final action of the commissioner pursuant to this section shall be subject to judicial review by the court of appeals.

Source: L. 92: Entire article R&RE, p. 1710, § 1, effective July 1; (3) amended, p. 1600, § 125, effective July 1. **L. 2017:** (1) and (2) amended, (SB 17-249), ch. 283, p. 1547, § 11, effective June 1.

Editor's note: This section is similar to former § 10-17-122 as it existed prior to 1992.

Cross references: For judicial review by the court of appeals, see § 24-4-106.

10-16-420. Penalties and enforcement. (1) The commissioner may, in lieu of suspension or revocation of a certificate of authority under section 10-16-417 and pursuant to the provisions of article 4 of title 24, C.R.S., levy an administrative penalty in an amount not less than one hundred dollars nor more than five hundred dollars, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that the commissioner calculates to be the damages suffered by enrollees or other members of the public.

(2) (a) If the commissioner, for any reason, has cause to believe that any violation of part 1 of this article 16 or of this part 4 has occurred or is threatened prior to levy of a penalty or suspension or revocation of a certificate of authority, the commissioner shall give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violations.

(b) Proceedings under this subsection (2) are not governed by any formal procedural requirements, and may be conducted in such manner as the commissioner deems appropriate under the circumstances.

(3) (a) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of part 1 of this article or this part 4.

(b) Within thirty days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of part 1 of this article or this part 4 have occurred. Such hearings shall be conducted pursuant to the provisions of article 4 of title 24, C.R.S.

(4) In the case of any violation of the provisions of part 1 of this article or this part 4, if the commissioner elects not to issue a cease-and-desist order or in the event of noncompliance with a cease-and-desist order issued pursuant to subsection (3) of this section, the commissioner may institute a proceeding to obtain injunctive relief or seek other appropriate relief through the attorney general.

(5) Any final action of the commissioner pursuant to this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 92: Entire article R&RE, p. 1710, § 1, effective July 1; (5) added, p. 1600, § 126, effective July 1. **L. 94:** (1) amended, p. 1630, § 29, effective May 31. **L. 2017:** (2) amended, (SB 17-249), ch. 283, p. 1547, § 13, effective June 1.

Editor's note: This section is similar to former § 10-17-124 as it existed prior to 1992.

10-16-421. Statutory construction and relationship to other laws. (1) Except for sections 10-1-102, 10-1-116, 10-1-117, 10-1-118, 10-3-128, and 10-3-208, part 2 of article 1 of this title, and parts 4 to 8 of article 3 of this title, and as otherwise provided in this article, the provisions of the insurance law and provisions of nonprofit hospital, medical-surgical, and health service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this part 4.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed as violating any provision of law relating to solicitation or advertising by health professionals; but such health professionals shall be individually subject to the laws, rules and regulations, and ethical provisions governing their individual profession.

(3) Any health maintenance organization authorized under part 1 of this article and this part 4 shall not be deemed to be practicing medicine and shall be exempt from the provisions of laws relating to the practice of medicine.

Source: L. 92: Entire article R&RE, p. 1712, § 1, effective July 1; (1) amended, p. 1600, § 127, effective July 1. **L. 94:** (1) amended, p. 1630, § 30, effective May 31. **L. 97:** (1) amended, p. 93, § 4, effective March 24. **L. 99:** (1) amended, p. 84, § 4, effective July 1. **L. 2001:** (1) amended, p. 287, § 13, effective March 30; (1) amended, p. 1050, § 34, effective July 1. **L. 2003:** (1) amended, p. 618, § 19, effective July 1. **L. 2004:** (1) amended, p. 991, § 13, effective August 4. **L. 2013:** (1) amended, (HB 13-1115), ch. 338, p. 1972, § 12, effective March 31, 2015. **L. 2014:** (1) amended, (HB 14-1315), ch. 295, p. 1218, §§ 9, 10, effective January 1, 2015. **L. 2016:** (1) amended, (SB 16-189), ch. 210, p. 757, § 17, effective June 6.

Editor's note: (1) This section is similar to former § 10-17-125 as it existed prior to 1992.

(2) Amendments to subsection (1) by House Bill 01-1064 and House Bill 01-1319 were harmonized.

10-16-421.5. Acquisition of control of or merger of a health maintenance organization. No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, (or by conversion or by exercise of any right to acquire) be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control

of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the health maintenance organization information required by sections 10-3-801, 10-3-802, 10-3-803 (2) to (11), and 10-3-803.5 and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner.

Source: L. 92: Entire section added, p. 1600, § 128, effective July 1. **L. 2014:** Entire section amended, (SB 14-152), ch. 312, p. 1354, § 3, effective July 1.

10-16-422. Filings and reports as public documents. All applications, filings, and reports required under part 1 of this article and this part 4 shall be treated as public documents.

Source: L. 92: Entire article R&RE, p. 1712, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-126 as it existed prior to 1992.

10-16-423. Confidentiality of health information. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of part 1 of this article or this part 4; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent; or as otherwise required or permitted by state or federal law. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure that the provider, who furnished such information to the health maintenance organization, is entitled to claim.

Source: L. 92: Entire article R&RE, p. 1712, § 1, effective July 1. **L. 2003:** Entire section amended, p. 1785, § 18, effective July 1.

Editor's note: The provisions of this section were similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

10-16-424. Commissioner's authority to contract. The commissioner, in carrying out his or her obligations pursuant to sections 10-16-402 (1)(b) and 10-16-417 (1), may contract with qualified persons concerning the determinations required to be made by the commissioner.

Source: L. 92: Entire article R&RE, p. 1713, § 1, effective July 1. **L. 2017:** Entire section amended, (SB 17-249), ch. 283, p. 1548, § 14, effective June 1.

Editor's note: The provisions of this section were similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

10-16-425. Applicability of provisions. Nothing contained in part 1 of this article or this part 4 shall be construed to affect or apply to any trust, association, or nonprofit corporation which is established and administered by an employer, a labor organization or labor organizations, or jointly by an employer and a labor organization or labor organizations, and which on or after July 6, 1973, provides or arranges for health-care services only for employees of such employer and members of the families of such employees, or only for members of such labor organization or labor organizations and the families of such members, and for no other person or persons.

Source: L. 92: Entire article R&RE, p. 1713, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-129 as it existed prior to 1992.

10-16-426. Medicare supplement benefit standards. Except for the requirements of section 10-18-105, the provisions of article 18 of this title shall not apply to all health maintenance organizations granted a certificate of authority under part 1 of this article or this part 4.

Source: L. 92: Entire article R&RE, p. 1713, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-132 as it existed prior to 1992.

10-16-427. Contractual relations. (1) Every contract between a health maintenance organization and a medical group, independent practice association, or health professional employed by a health maintenance organization shall be written and include a hold harmless provision which shall provide that in the event a health maintenance organization fails to pay for health-care services rendered to an enrollee pursuant to a written contract between the health maintenance organization and a medical group, independent practice association, or health professional employed by the health maintenance organization, the enrollee shall not be liable for any moneys owed by the health maintenance organization.

(2) No medical group, independent practice association, or health professional employed by a health maintenance organization referred to in subsection (1) of this section or any agent, trustee, or contractee thereof may maintain any action against an enrollee for sums owed by the health maintenance organization.

Source: L. 92: Entire article R&RE, p. 1713, § 1, effective July 1.

Editor's note: This section is similar to former § 10-17-133 as it existed prior to 1992.

10-16-428. Prohibition concerning state-funded medical assistance. (Repealed)

Source: L. 92: Entire article R&RE, p. 1714, § 1, effective July 1. **L. 94:** Entire section repealed, p. 1594, § 2, effective July 1.

Editor's note: This section was similar to former § 10-17-134 as it existed prior to 1992.

10-16-429. Termination of contract. A health maintenance organization shall not retroactively terminate a policy or contract issued pursuant to this part 4 except for fraud or intentional misrepresentation. For any termination other than for fraud or intentional misrepresentation, the health maintenance organization shall provide notice thirty days in advance of the cancellation of the policy or contract.

Source: L. 2013: Entire section added, (HB 13-1266), ch. 217, p. 981, § 34, effective May 13.

PART 5

PREPAID DENTAL CARE PLANS

10-16-501. Legislative declaration. It is the policy of the general assembly and the intent and purpose of this part 5 to promote the availability and assure the competent quality of dental care on a prepaid basis, and to thereby promote the health and welfare of the people of Colorado. The general assembly recognizes that health-care coverage may be offered to the citizens of this state by various entities with distinct organizational and functional forms. The placement of this part 5 in this article should in no way be construed so as to alter the distinct organizational and functional character of prepaid dental care plans or to alter the legal distinctions between such plans and other health-care coverage entities.

Source: L. 92: Entire article R&RE, p. 1714, § 1, effective July 1. **L. 94:** Entire section amended, p. 1649, § 92, effective May 31.

Editor's note: This section is similar to former § 10-16.5-102 as it existed prior to 1992.

10-16-502. Establishment of prepaid dental care plan organizations. (1) No person, unless otherwise authorized pursuant to this title, may establish or operate a prepaid dental care plan organization in this state or sell or offer to sell, or solicit offers to purchase, or receive advanced or periodic consideration in conjunction with a prepaid dental care plan without obtaining and maintaining a certificate of authority pursuant to part 1 of this article and this part 5.

(2) Within ninety days after January 1, 1980, every prepaid dental care plan organization operating in this state and pursuant to part 1 of this article and this part 5 shall submit an application for a certificate of authority to the commissioner. Each such applicant may continue to operate as an organization until the commissioner acts upon the application.

(3) A prepaid dental care plan organized under part 1 of this article and this part 5 shall be subject to part 5 and part 11 of article 3 of this title but shall not be subject to any other laws of this state relating to insurance or insurance companies.

Source: L. 92: Entire article R&RE, p. 1714, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16.5-104 as it existed prior to 1992.

10-16-503. Application for certificate of authority. (1) An application for a certificate of authority to operate as a prepaid dental care plan organization formed under part 1 of this article 16 and this part 5 shall be filed with the commissioner on a form prescribed by the commissioner. Such application shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

(a) A copy of any basic organizational document of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments to such documents;

(b) A copy of all bylaws, rules and regulations, or similar documents regulating the conduct of the internal affairs of the applicant;

(c) A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the affairs of the applicant, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(d) If the prepaid dental care plan organization is a corporation, evidence that the board of directors of such corporation includes:

(I) Dentists, duly licensed pursuant to article 220 of title 12, who have contracted with the corporation to render dental care services to enrollees;

(II) Enrollees of the prepaid dental care plan, who shall comprise at least one-third of the members of the board;

(e) A copy of any contract made or to be made between any providers or persons listed in paragraph (c) of this subsection (1) and the applicant;

(f) A statement generally describing the prepaid dental care plan organization and its dental plan or plans, facilities, and personnel;

(g) A copy of the form of enrollee coverage to be issued to the enrollees;

(h) A copy of the form of any group contract which is to be issued to employers, unions, trustees, or other applicants;

(i) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of part 1 of this article and this part 5.

(j) A description of the proposed method of marketing the prepaid dental care plan, a financial plan which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding;

(k) A power of attorney duly executed by such applicant, if not domiciled in this state, appointing the commissioner as the true and lawful attorney of such applicant in and for this state, upon whom all lawful process in any legal action or proceeding against the prepaid dental care plan organization on a cause of action arising in this state may be served;

(l) Repealed.

(m) Such other information as the commissioner may require.

(2) Any existing domestic prepaid dental care plan organization with fifteen hundred or more dental plan enrollees on January 1, 1980, shall have three years to meet the requirements of sections 10-16-505 and 10-16-506. However, such organization shall submit with its application or certificate of authority, a plan approved by the commissioner to meet the requirements of sections 10-16-505 and 10-16-506 at ten percent the first year of operation, fifty percent the second year of operation, and one hundred percent the third year of operation. In addition to exemptions provided elsewhere in this subsection (2), the commissioner may grant a one-year waiver from the provisions of this subsection (2).

(3) Within ten days following any significant modification of any matter furnished pursuant to subsection (1) of this section, a prepaid dental care plan organization shall file notice of such modification together with such supporting documents as are necessary to fully explain the modification with the commissioner.

Source: L. 92: Entire article R&RE, p. 1715, § 1, effective July 1; (1)(l) repealed, p. 1601, § 129, effective July 1. **L. 2019:** IP(1) and (1)(d)(I) amended, (HB 19-1172), ch. 136, p. 1657, § 54, effective October 1.

Editor's note: This section is similar to former § 10-16.5-105 as it existed prior to 1992.

10-16-504. Issuance of certificate of authority. (1) Issuance of a certificate of authority shall be granted by the commissioner if the commissioner is satisfied that the following conditions are met:

(a) The requirements of section 10-16-503 have been fulfilled;

(b) The prepaid dental care plan organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees;

(c) The agreement with providers for the provision of prepaid dental care services has been deemed sufficient;

(d) Each officer responsible for conducting the affairs of the prepaid dental care plan organization has filed with the commissioner, subject to the commissioner's approval, a fidelity bond in the amount of fifty thousand dollars.

(2) A certificate of authority shall expire at 12 midnight on June 30 next following the date of issuance or renewal and shall be renewed as provided in section 10-3-117. A prepaid dental care plan organization shall pay a renewal fee as prescribed pursuant to section 10-3-207.

Source: L. 92: Entire article R&RE, p. 1717, § 1, effective July 1; (2) amended, p. 1601, § 130, effective July 1.

Editor's note: This section is similar to former § 10-16.5-106 as it existed prior to 1992.

10-16-505. Guarantee fund deposit. (1) A prepaid dental care plan organization subject to the provisions of part 1 of this article and this part 5 shall place on deposit with the commissioner a guarantee fund of cash, approved securities, or letter of credit approved by the commissioner in the amount of two dollars per enrollee for all enrollees entitled to dental care

services pursuant to contracts issued by the prepaid dental care plan or ten thousand dollars, whichever is greater.

(2) The cash or securities representing the guarantee fund required by this section shall be deposited with the commissioner under joint control in the same manner as prescribed in sections 10-3-206, 10-3-210, and 10-3-211.

(3) An unpaid final judgment arising upon an enrollee coverage shall be a lien on the deposit prescribed by subsection (1) of this section, subject to execution after thirty days from the entry of final judgment. If the deposit is reduced, it shall be replenished within ninety days by the prepaid dental care plan organization.

(4) Upon liquidation or dissolution of a prepaid dental care plan organization formed under part 1 of this article and this part 5 and the satisfaction of all its debts and liabilities, any balance remaining of the deposit prescribed in subsection (1) of this section together with any other assets of the prepaid dental care plan organization shall be returned by the commissioner to the prepaid dental care plan organization.

(5) The deposit prescribed by subsection (1) of this section shall not apply with respect to a prepaid dental care plan organization which is funded by a federal, state, or municipal government or by any political subdivision thereof to the extent and for such period of time that the prepaid dental care plan organization can demonstrate to the commissioner the presence of operational commitments from such sources equivalent to such deposit.

Source: L. 92: Entire article R&RE, p. 1717, § 1, effective July 1; (2) amended, p. 1601, § 131, effective July 1. **L. 96:** (2) amended, p. 97, § 3, effective July 1.

Editor's note: This section is similar to former § 10-16.5-107 as it existed prior to 1992.

10-16-506. Reserve requirement - exception. (1) A prepaid dental care plan organization formed under part 1 of this article and this part 5 at all times shall maintain for protection of enrollees a financial reserve consisting of two percent of prepaid charges collected from enrollees for the plan, until such reserve totals five hundred thousand dollars. Such reserve shall be in addition to the deposit prescribed by section 10-16-505.

(2) The reserve prescribed by subsection (1) of this section shall not apply with respect to a prepaid dental care plan organization which is funded by a federal, state, or municipal government or by any political subdivision thereof and which meets the requirements of section 10-16-505 (5).

Source: L. 92: Entire article R&RE, p. 1718, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16.5-108 as it existed prior to 1992.

10-16-507. Enrollee coverage by prepaid dental care plan organizations - form filing requirements. (1) Every enrollee in a prepaid dental care plan shall be issued an enrollee coverage form by the prepaid dental care plan organization.

(2) (a) No contract issued, renewed, or reinstated by a prepaid dental care plan organization shall contain any provision which limits or excludes payments under hospital or

medical benefits coverage to or on behalf of the enrollee because the enrollee is eligible for or receiving medical assistance benefits under articles 4, 5, and 6 of title 25.5, C.R.S.

(b) The requirements of paragraph (a) of this subsection (2) shall apply to all such contracts issued, renewed, or reinstated on or after August 1, 1984.

(3) (a) For prepaid dental care plans, the prepaid dental care plan organization shall not issue or deliver enrollee coverage or an amendment, advertising matter, or sales material to any person in this state until the carrier has filed a copy of the form of the enrollee coverage or amendment, advertising matter, or sales material with the commissioner.

(b) The enrollee coverage must contain a clear and complete statement, if a contract, or a reasonably complete summary, if a certificate of contract, of:

(I) The prepaid dental care services to which the enrollee is entitled under the prepaid dental care plan;

(II) Any limitations of the services, kind of services, or benefits to be provided, including any deductible or copayment feature;

(III) Where and in what manner information is available as to how services may be obtained;

(IV) The enrollee's obligation respecting charges for the prepaid dental care plan.

(c) The enrollee coverage, advertising matter, and sales material must not contain any provisions or statements that are unjust, unfair, inequitable, misleading, or deceptive; encourage misrepresentation; or are untrue or misleading.

(d) The commissioner shall approve any form of enrollee coverage if the requirements of paragraphs (b) and (c) of this subsection (3) are met and the prepaid dental care plan organization is able, in the judgment of the commissioner, to meet its financial obligations under the enrollee coverage. It is unlawful to issue the form until approved by the commissioner. If the commissioner fails to disapprove a form of enrollee coverage within thirty days after the filing, the form is deemed approved. If the commissioner disapproves a form of enrollee coverage, advertising matter, or sales material, the commissioner shall notify the prepaid dental care plan organization, specifying the reasons for disapproval. The commissioner shall grant a hearing on a disapproval within fifteen days after the commissioner receives a request in writing from the prepaid dental care plan organization.

Source: L. 92: Entire article R&RE, p. 1719, § 1, effective July 1. **L. 2006:** (2)(a) amended, p. 2000, § 39, effective July 1. **L. 2013:** (3) added with relocations, (HB 13-1266), ch. 217, p. 981, § 35, effective May 13.

Editor's note: (1) This section is similar to former § 10-16.5-109 as it existed prior to 1992.

(2) Subsection (3) is similar to former § 10-16-107 (4) as it existed prior to 2013.

10-16-508. Examination of prepaid dental care plan organization. (1) The commissioner may visit once in each six months for the first three years after organization and once each year thereafter, or more often if deemed necessary by the commissioner, each prepaid dental care plan organization organized under part 1 of this article and this part 5 and examine its financial condition and its ability to meet its liabilities and its compliance with the laws of this state affecting the conduct of its business. The commissioner may visit and examine annually

each prepaid dental care plan organization not organized under the laws of this state but authorized to transact business in this state.

(2) The commissioner may in like manner examine each prepaid dental care plan organization applying for an initial certificate of authority to do business in this state under part 1 of this article and this part 5.

(3) In lieu of making an examination, the commissioner may accept a full report of the most recent examination of a foreign or alien prepaid dental care plan organization, certified to by the appropriate examining official of another state, territory, commonwealth, or district of the United States.

Source: L. 92: Entire article R&RE, p. 1719, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16.5-110 as it existed prior to 1992.

10-16-509. Operational expenses. No more than thirty percent of prepaid charges in the first year of any contract, twenty-five percent of prepaid charges in the second year of any contract, and twenty percent of prepaid charges in any subsequent contract year shall be used for the marketing and administrative expenses of a prepaid dental care plan organization, including all costs related to soliciting enrollees and providers.

Source: L. 92: Entire article R&RE, p. 1720, § 1, effective July 1.

Editor's note: This section is similar to former § 10-16.5-112 as it existed prior to 1992.

10-16-510. Suspension or revocation of certificate of authority. (1) The commissioner may suspend or revoke any certificate of authority issued to a prepaid dental care plan organization pursuant to part 1 of this article and this part 5 if the commissioner finds that any of the following conditions exist:

(a) The prepaid dental care plan organization is operating significantly in contravention of its basic organizational document or its prepaid dental care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to section 10-16-503, unless amendments to such submissions have been filed with and approved by the commissioner;

(b) The prepaid dental care plan organization issues evidence of coverage or uses a schedule of charges for prepaid dental care services which do not comply with the requirements of section 10-16-507;

(c) The prepaid dental care plan does not provide or arrange for basic prepaid dental care services;

(d) The prepaid dental care plan organization is unable to fulfill its obligations to furnish prepaid dental care services as required under its care plan;

(e) The prepaid dental care plan organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The prepaid dental care plan organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation pursuant to section 10-16-503 (1)(d);

(g) The prepaid dental care plan organization, or any person on its behalf, has advertised or merchandised its prepaid dental care services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(h) The continued operation of the prepaid dental care plan organization would be hazardous to its enrollees;

(i) The prepaid dental care plan organization has otherwise failed to substantially comply with part 1 of this article or this part 5.

(2) When the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the prepaid dental care plan organization in writing specifically stating the grounds for suspension or revocation and fixing a time of at least twenty days but not more than sixty days thereafter for a hearing on the matter.

(3) After such hearing, or upon the failure of the prepaid dental care plan organization to appear at such hearing, the commissioner shall take action as is deemed advisable on written findings which shall be mailed to the prepaid dental care plan organization.

(4) The provisions of article 4 of title 24, C.R.S., shall apply to proceedings under this section to the extent they are not in conflict with subsections (2) and (3) of this section.

(5) (a) The commissioner may, in lieu of suspension or revocation of a certificate of authority and pursuant to the provisions of article 4 of title 24, C.R.S., levy an administrative penalty in an amount not less than one hundred dollars nor more than five hundred dollars, if reasonable notice in writing is given of the intent to levy the penalty and the prepaid dental care plan organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that the commissioner calculates to be the damages suffered by enrollees or other members of the public.

(b) (I) If the commissioner, for any reason, has cause to believe that any violation of part 1 of this article or this part 5 has occurred or is threatened, prior to levy of a penalty or suspension or revocation of a certificate of authority, the commissioner shall give notice to the prepaid dental care plan organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(II) Proceedings under this paragraph (b) shall not be governed by any formal procedural requirements and may be conducted in such manner as the commissioner may deem appropriate under the circumstances.

(c) (I) The commissioner may issue an order directing a prepaid dental care plan organization or a representative of a prepaid dental care plan organization to cease and desist from engaging in any act or practice in violation of the provisions of part 1 of this article or this part 5.

(II) Within thirty days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of part 1 of this article

or this part 5 have occurred. Such hearings shall be conducted pursuant to the provisions of article 4 of title 24, C.R.S.

(d) In the case of any violation of the provisions of part 1 of this article or this part 5 if the commissioner elects not to issue a cease-and-desist order, or in the event of noncompliance with a cease-and-desist order issued pursuant to paragraph (c) of this subsection (5), the commissioner may institute a proceeding to obtain injunctive relief or seek other appropriate relief through the attorney general.

(6) When the certificate of authority of a prepaid dental care plan organization is suspended, the prepaid dental care plan organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

(7) When the certificate of authority of a prepaid dental care plan organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing prepaid dental care coverage.

(8) Any final action of the commissioner pursuant to this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 92: Entire article R&RE, p. 1720, § 1, effective July 1; (8) added, p. 1602, § 132, effective July 1.

Editor's note: This section is similar to former § 10-16.5-114 as it existed prior to 1992.

10-16-511. Rehabilitation, liquidation, or conservation of prepaid dental care plan organization. Any rehabilitation, liquidation, or conservation of a prepaid dental care plan organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurer and shall be conducted pursuant to part 5 of article 3 of this title.

Source: L. 92: Entire article R&RE, p. 1723, § 1, effective July 1; entire section amended, p. 1499, § 31, effective July 1.

Editor's note: (1) This section is similar to former § 10-16.5-115 as it existed prior to 1992.

(2) Amendments made to § 10-16.5-115 by section 31 of chapter 203, Session Laws of Colorado 1992, have been harmonized with this section since article 16.5 was repealed and the substantive provisions of former § 10-16.5-115 were moved to this section.

10-16-512. Other laws applicable. In addition to the provisions of part 1 of this article and this part 5, the laws governing insurance companies, except as they are inconsistent with the

provisions or purposes of this article, shall apply to prepaid dental care plans regulated pursuant to the provisions of part 1 of this article and this part 5.

Source: L. 92: Entire section added, p. 1602, § 133, effective July 1.

PART 6

ACCOUNTABILITY OF INDEPENDENT MEDICAL EXAMINERS TO THEIR PATIENTS

10-16-601. Legislative declaration. The general assembly declares that the intent of this part 6, which shall only apply to this title and not to articles 40 to 47 of title 8, C.R.S., is to ensure that patients have access to the best possible health-care decisions and information and to increase the confidence of consumers that doctors will be truly independent medical examiners.

Source: L. 96: Entire part added, p. 566, § 1, effective April 24.

10-16-602. Definitions. As used in this part 6, unless the context otherwise requires:

(1) "Doctor" means a person licensed as a doctor under title 12, C.R.S., to provide health care to a patient.

(2) "Insurer" means a sickness and accident insurer and any health maintenance organization; fraternal benefit society; nonprofit hospital, medical-surgical, and health services corporation; prepaid health plans; or other entity providing health-care coverage or health benefits or health-care services, whether as a principal, indemnitor, surety, or contractor, authorized by the commissioner to conduct business in Colorado. "Insurer" also includes a self-insurer providing any health coverage or health benefit or health-care services certificate, agreement, contract, policy, or plan; except that the term "insurer" under this part 6 shall apply only to this part 6 and shall not include an insurer or self-insured employer under articles 40 to 47 of title 8, C.R.S.

(3) "Patient" means an individual covered by, or denoted as an insured, subscriber, enrollee, or purchaser under any health coverage or health benefit or health-care services certificate, agreement, contract, policy, or plan. "Patient" also includes a covered employee or dependent of an insured person.

Source: L. 96: Entire part added, p. 566, § 1, effective April 24. **L. 2004:** (2) amended, p. 903, § 25, effective May 21.

10-16-603. Independent medical examinations - governing standard. All independent medical examinations performed by a doctor shall be performed in accordance with generally accepted professional standards of practice or care. It shall be unprofessional conduct for a doctor to perform an independent medical examination not in accordance with generally accepted professional standards of practice or care.

Source: L. 96: Entire part added, p. 567, § 1, effective April 24.

10-16-604. Financial interest in future care of patient prohibited. No doctor that performs an independent medical examination shall have a financial or economic interest in the type or duration of treatment or the results of the examination.

Source: L. 96: Entire part added, p. 567, § 1, effective April 24.

10-16-605. Independence of examiners. No insurer, employer, employee, patient, or agent or representative thereof shall attempt to dictate to any doctor performing an independent medical examination the type or duration of treatment or the results of the examination.

Source: L. 96: Entire part added, p. 567, § 1, effective April 24.

10-16-606. Applicability. Nothing in this part 6 shall be construed to apply to any action under articles 40 to 47 of title 8, C.R.S.

Source: L. 96: Entire part added, p. 567, § 1, effective April 24.

PART 7

CONSUMER PROTECTION STANDARDS ACT FOR THE OPERATION OF MANAGED CARE PLANS

10-16-701. Short title. This part 7 shall be known and may be cited as the "Consumer Protection Standards Act for the Operation of Managed Care Plans".

Source: L. 97: Entire part added, p. 1325, § 2, effective July 1.

10-16-702. Legislative declaration. (1) The general assembly hereby finds, determines, and declares that the purposes of this part 7 are:

(a) To incorporate consumer protections in the creation and maintenance of provider networks by carriers;

(b) To establish standards to assure the adequacy, accessibility, and quality of health-care services offered under a managed care plan; and

(c) To establish requirements for written agreements between carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons.

Source: L. 97: Entire part added, p. 1325, § 2, effective July 1.

10-16-703. Applicability. This part 7 applies to all managed care plans, except for workers' compensation and automobile insurance contracts, that are issued, renewed, extended, or modified on or after January 1, 1998.

Source: L. 97: Entire part added, p. 1325, § 2, effective July 1.

10-16-704. Network adequacy - required disclosures - balance billing - rules - legislative declaration - definitions. (1) A carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health-care services twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:

(a) Provider-covered person ratios by specialty, which may include the use of providers through telehealth for services that may appropriately be provided through telehealth;

(b) Primary care provider-covered person ratios;

(c) Geographic accessibility, which in some circumstances may require the crossing of county or state lines;

(d) Waiting times for appointments with participating providers;

(e) Hours of operation;

(f) The volume of technological and specialty services available to serve the needs of covered persons requiring covered technologically advanced or specialty care; and

(g) An adequate number of accessible acute care hospital services within a reasonable distance, travel time, or both.

(1.5) (a) (I) The commissioner shall promulgate rules, consistent with federal law, to:

(A) Require a carrier providing managed care plans to include essential community providers in the carrier's network; or

(B) Allow a carrier providing managed care plans that provides a majority of covered professional services through physicians employed by the carrier or through a single contracted medical group to comply with the alternate standard for essential community providers permitted under federal law.

(II) For purposes of the rules, "essential community providers" includes providers that serve predominately low-income, medically underserved individuals, such as health-care providers defined in the federal law and under part 4 of article 5 of title 25.5; except that nothing in this subsection (1.5) requires any carrier to provide coverage for any specific medical procedure.

(b) The commissioner may promulgate rules to require carriers to be accredited by an accrediting entity recognized by the United States department of health and human services.

(2) (a) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

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

(A) The covered person resides outside of a metropolitan statistical area or primary metropolitan statistical area and the carrier has no participating providers to provide covered benefits in such geographic area; and

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

(II) Subsection (2)(b)(I) of this section shall not apply to:

(A) Emergency services or primary care providers; and

(B) Cases in which the covered person is so severely ill or impaired that such person is unable to move from place to place without the aide of a mechanical device; has a physical or mental condition, verified by a physician licensed to practice medicine in this state or practicing medicine pursuant to section 12-240-107 (3)(i), that substantially limits the person's ability to move from place to place; or suffers from a physical hardship such that travel would threaten the safety or welfare of the covered person as verified by the covered person's in-network treating physician. Decisions in which a carrier contests the covered person's ability to travel may be appealed pursuant to section 10-16-113 or 10-16-113.5.

(c) (I) In cases where, as a result of the provisions of subparagraph (I) of paragraph (b) of this subsection (2), a covered person is required to travel a reasonable distance beyond the requirements of subsection (6) of this section for an adequate network in order to receive services from a participating provider, and the covered person knowingly seeks services from a nonparticipating provider, the carrier shall be responsible to pay to the provider the lesser of:

(A) The nonparticipating provider's bill charges;

(B) A negotiated rate; or

(C) In the absence of a negotiated rate, the greater of the carrier's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area. Nothing in this paragraph (c) shall require either a carrier or a nonparticipating provider to attempt to negotiate a reimbursement rate.

(II) Upon request the carrier shall disclose to the covered person or the nonparticipating provider whether the amount reimbursed to the nonparticipating provider was the nonparticipating provider's billed charges, a negotiated rate, or the greater of the carrier's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area.

(III) A nonparticipating provider may balance bill the covered person in the event that the reimbursement rate described in subparagraph (I) of this paragraph (c) is not equal to the billed charges.

(IV) The commissioner shall promulgate rules defining the relevant geographic area for the purposes of sub-subparagraph (C) of subparagraph (I) of this paragraph (c). In the promulgation of such rules, the commissioner shall group together counties with similar demographic and economic characteristics. Such characteristics shall include, but not be limited to, average per capita income, the cost of housing, general cost of living, poverty and unemployment levels, or the primary economic base of the county.

(d) The carrier shall provide, in conspicuous, bold-faced type, an understandable disclosure in policy contract materials, certificates of coverage for a policyholder, and marketing materials about the following:

(I) Specific counties of the state where there are no participating providers;

(II) The circumstances under which the covered person may be balanced billed by nonparticipating providers; and

(III) The mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers for specific covered health-care services.

(e) (I) A carrier shall make available upon request from the covered person or the nonparticipating provider, from whom the covered person is seeking treatment, the carrier's usual, customary, and reasonable rate for reimbursement for specific health-care services.

(II) The commissioner may, upon receipt of one or more complaints from a covered person or a covered person's nonparticipating treating provider, review the carrier's usual, customary, and reasonable rate to determine if the rate is established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.

(III) The carrier's methodology for determining usual, customary, and reasonable reimbursement rates shall be applied in a uniform manner statewide; except that geographic adjustments may be made apart from the standard methodology.

(f) Repealed.

(g) A health maintenance organization offering health benefits in this state may:

(I) Offer health benefit coverage in accordance with paragraph (i) of this subsection (2) to a small employer that is not located, or whose employees do not work or reside, within the health maintenance organization's geographic service area;

(II) Offer health benefit coverage in accordance with paragraph (i) of this subsection (2) in a geographic area within the carrier's service area in which a health maintenance organization is unable to maintain an adequate network and is able to demonstrate to the commissioner upon request that the carrier has made unsuccessful good faith efforts to contract with local providers on reasonable terms; or

(III) Offer coverage pursuant to this paragraph (g) within a geographic area consistent with the requirements of section 10-16-105 (1) and (4).

(h) The health maintenance organization shall provide a disclosure to a small employer and its employees who purchase health insurance coverage under the circumstance described in this paragraph (h). Such disclosure shall also be given in writing to all interested policyholders and certificate holders as part of the sales and marketing materials before the insurer or entity approves an application for insurance from an insured. The disclosure shall contain the following statement: "Interested policyholders, certificate holders, and enrollees are hereby given notice that this small group policy requires that an insured travel outside of the geographic area to receive covered health benefits." The carrier shall, in a conspicuous location on the policy contract materials, certificates of coverage for a policyholder, and marketing materials, provide the disclosure required by this paragraph (h) in bold-faced, twelve-point type and all capital letters.

(i) (I) A health maintenance organization that offers coverage pursuant to this section may require that a covered person travel a reasonable distance beyond the area specified under subsection (6) of this section in order to receive services from a participating provider. Except for emergency services and benefits available for out-of-network services, in such cases where the covered person is required to travel a reasonable distance to receive services from a participating provider and knowingly seeks services from a nonparticipating provider, the health maintenance organization shall be responsible to pay for the lesser of:

(A) The provider's billed charges;

(B) A negotiated rate; or

(C) In the absence of a negotiated rate, the greater of the health maintenance organization's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area.

(II) Upon request, the health maintenance organization shall disclose to the covered person or the nonparticipating provider whether the amount reimbursed to the nonparticipating provider was the nonparticipating provider's billed charges, a negotiated rate, or the greater of the carrier's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area.

(j) Nothing in paragraph (i) of this subsection (2) shall require either a carrier or a nonparticipating provider to attempt to negotiate a reimbursement rate.

(k) A nonparticipating provider may balance bill the covered person in the event that the reimbursement rate described in paragraph (i) of this subsection (2) is not equal to the provider's billed charges.

(l) The provisions of subsection (2)(i) of this section shall not apply to cases in which the covered person is so severely ill or impaired that such person is unable to move from place to place without the aid of a mechanical device; has a physical or mental condition, verified by a physician licensed to practice medicine in this state or practicing medicine pursuant to section 12-240-107 (3)(i), that substantially limits the person's ability to move from place to place; or suffers from a physical hardship such that travel would threaten the safety or welfare of the covered person as verified by the covered person's in-network treating physician. Decisions in which a carrier contests the covered person's ability to travel may be appealed pursuant to section 10-16-113 or 10-16-113.5.

(m) Notwithstanding any other provision of law, on and after September 1, 2006, for the duration of the term of a policy in effect when the insured pays the amount charged for a covered health-care service and seeks reimbursement from a carrier for such covered health-care service, the insured shall be liable for no more than the in-network copayment, coinsurance, and deductible for such service if:

(I) The insured seeks reimbursement from the carrier within twelve months after the provision of the service;

(II) Preauthorization is not required for the particular type of service provided; and

(III) A contract between the provider and the carrier was in place when the service was provided.

(2.5) (a) In the event of a material change to the carrier's network that could result in the application of subparagraph (I) of paragraph (b) of subsection (2) of this section, the carrier shall provide at least forty-five days prior to the change, in conspicuous bold-faced type, an understandable disclosure to all affected covered persons about the following:

(I) Specific network changes in the geographic area;

(II) The circumstances under which the covered person may be balance billed by nonparticipating providers; and

(III) The mechanisms to obtain the carrier's reimbursement rates to a nonparticipating provider for specific covered health-care services.

(b) In the event of a material change to the carrier's network that could result in the application of subparagraph (I) of paragraph (b) of subsection (2) of this section, the carrier shall provide notice of the change to the commissioner at least fifteen days prior to the change. Such notice may be provided by electronic means.

(c) In the event that a network of a managed care plan with out-of-network benefits that is not a health maintenance organization or a health maintenance organization with a point of

service plan changes, and notice to covered persons is provided pursuant to section 10-16-705 (7), such notice shall include an understandable disclosure of:

(I) The circumstances under which the covered person may be balance billed by nonparticipating providers; and

(II) The mechanisms to obtain the carrier's reimbursement rate to nonparticipating providers for specific covered health-care services.

(d) In the event that a contract with a participating provider terminates or is terminated, notification to covered persons shall be provided pursuant to section 10-16-705 (7).

(2.7) (a) Nothing in subsection (2) or (2.5) of this section shall delay access to health-care services.

(b) Nothing in subparagraph (I) of paragraph (b) of subsection (2) of this section shall exempt a carrier from having a participating provider for all covered benefits. In any case where the carrier has no participating providers to provide a covered benefit, the provisions of paragraph (a) of subsection (2) of this section shall apply.

(3) (a) (I) In 1997, the general assembly enacted this part 7 with the express intent to incorporate consumer protections into the creation and maintenance of provider networks and to establish standards to assure the adequacy, accessibility, and quality of health-care services offered under a managed care plan.

(II) The general assembly hereby finds, determines, and declares that there are situations in which insured consumers receive health-care services, including procedures approved by their insurance carrier, in a network facility, with a primary provider that is a network provider, but in which other health-care professionals assisting with such procedures may not be in-network providers. In such situations, the consumer is not aware that the assisting providers are out-of-network providers. Further, the consumer may have little or no direct contact with the assisting health-care professionals. The division of insurance has interpreted the network adequacy provisions in this section, along with the provisions related to relationships between an insurer and a health-care provider in section 10-16-705, to hold the consumer harmless for additional charges from out-of-network providers for care rendered in a network facility. The division of insurance's interpretation of these statutes was challenged by an insurer and invalidated by a division of the Colorado court of appeals in *Pacific Life & Annuity Co. v. Colorado Div. of Ins.*, no. 04CA2169 (slip op.) (Feb. 23, 2006).

(III) The general assembly finds, determines, and declares that the division has correctly interpreted this section to protect a covered person from the additional expense charged by a provider who is an out-of-network provider, and has properly required carriers to hold the covered person harmless. The division does not have regulatory authority over all health plans. Some consumers are enrolled in self-funded health insurance programs that are governed under the federal "Employee Retirement Income Security Act of 1974", 29 U.S.C. sec. 1001 et seq. Therefore, health-care facilities, carriers, and providers must provide consumers with disclosures about the potential impact of receiving services from an out-of-network provider or health-care facility and their rights under this section. Covered persons must have access to accurate information about their health-care bills and their payment obligations in order to enable them to make informed decisions about their health care and financial obligations.

(IV) Repealed.

(V) Therefore, the general assembly finds, determines, and declares that the purpose of Senate Bill 06-213 is to codify the interpretation of the division of insurance that holds

consumers harmless for charges over and above the in-network rates for services rendered in a network facility.

(b) When a covered person receives services or treatment in accordance with plan provisions at an in-network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit. Covered services or treatment rendered at an in-network facility, including covered ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at an in-network facility, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider. A payment made by a covered person pursuant to this subsection (3)(b) must be applied to the covered person's in-network deductibles and out-of-pocket maximum amounts and in the same manner as if the cost-sharing payments were made to an in-network provider at an in-network facility.

(c) Repealed.

(d) (I) If a covered person receives covered services at an in-network facility from an out-of-network provider, the carrier shall pay the out-of-network provider directly and in accordance with this subsection (3)(d). At the time of the disposition of the claim, the carrier shall advise the out-of-network provider and the covered person of any required coinsurance, deductible, or copayment.

(II) When the requirements of subsection (3)(b) of this section apply, the carrier shall reimburse the out-of-network provider directly in accordance with section 10-16-106.5 the greater of:

(A) One hundred ten percent of the carrier's median in-network rate of reimbursement for that service in the same geographic area; or

(B) The sixtieth percentile of the in-network rate of reimbursement for the same service in the same geographic area for the prior year based on commercial claims data from the all-payer health claims database created in section 25.5-1-204.

(III) Payment made by a carrier in compliance with this subsection (3)(d) is presumed to be payment in full for the services provided, except for any coinsurance, deductible, or copayment amount required to be paid by the covered person.

(IV) This subsection (3)(d) does not preclude the carrier and the out-of-network provider from voluntarily negotiating an independent reimbursement rate. If the negotiations fail, the reimbursement rate required by subsection (3)(d)(II) of this section applies.

(V) This subsection (3)(d) does not apply when a covered person has received notice and given consent as required by section 12-30-112 or 25-3-121, as applicable, to use an out-of-network provider in compliance with the federal "No Surprises Act".

(VI) Repealed.

(4) When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse. If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person.

(4.5) (a) All claims paid by a carrier shall be considered final unless adjustments are made pursuant to this subsection (4.5).

(b) Except as otherwise provided in this subsection (4.5), adjustments to claims by the provider or the carrier shall be made within the time period set out in a contract between the

provider and the carrier. Such time period shall be the same for the provider and the carrier and shall not exceed twelve months after the date of the original explanation of benefits.

(c) Except as otherwise provided in this subsection (4.5), if there is no contract between a provider and a carrier, adjustments to claims paid to providers shall be made within twelve months after the date of the original explanation of benefits. The time period for adjustments shall be the same for the provider and the carrier.

(d) (I) Adjustments to claims paid under a risk assumption or risk sharing agreement shall be made within six months after the last date of service for a period for which a settlement is being reconciled. The period for which a settlement is reconciled shall not exceed twelve months.

(II) For purposes of this paragraph (d), "risk assumption" and "risk sharing" refer to a transaction whereby the chance of loss, including the expenses for the delivery of service, with respect to the health care of a person is transferred to or shared with another entity in return for full consideration. Such transactions include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnification agreements. Such transactions do not include fee-for-service arrangements, per diem payments, and diagnostic-related group payment agreements.

(e) Adjustments to claims related to coordination of benefits with federally funded health benefit plans, including medicare and medicaid, shall be made within thirty-six months after the date of service.

(f) A carrier shall not retroactively adjust a claim based on eligibility if the provider received verification of eligibility within two business days prior to the delivery of services, unless the policyholder notified the carrier of an individual's ineligibility pursuant to section 10-16-103.5 (1).

(g) (I) (A) In circumstances where a carrier determines that a premium has not been received during a grace period required by section 10-16-202 (4) for an individual policy, the carrier may report to the provider that eligibility is contingent on payment of the premium due and that eligibility cannot be confirmed for the period that the premium is outstanding. In such cases, a carrier shall comply with the requirements of section 10-16-705 (12)(b) and (12)(c).

(B) If a carrier fails to report to the provider that eligibility is contingent on payment of premium due pursuant to sub-subparagraph (A) of this subparagraph (I), the carrier shall comply with paragraph (f) of this section.

(II) In circumstances where the provider receives information from the carrier that coverage is contingent upon receipt of a premium, the requirements of section 10-16-705 (3) shall not apply and the provider may collect payment for services from the enrollee.

(III) If the provider has collected payment from the enrollee and subsequently receives payment from the carrier, the provider shall reimburse the enrollee less any applicable copayments, deductibles, or coinsurance amounts.

(h) In circumstances where a carrier determines that a premium has not been received during a grace period required by section 10-16-214 (3) for a group policy, the carrier may report to the provider that the carrier is not required to pay for health-care services rendered to an enrollee during a time in which the carrier can demonstrate that the policyholder has secured coverage with another carrier.

(i) Nothing in this subsection (4.5) shall prohibit the carrier from requiring the enrollee to reimburse the carrier for claims paid by the carrier to the provider if:

(I) A change in eligibility status has occurred making the enrollee ineligible for coverage on the date services were provided; or

(II) An enrollee has committed fraud or material misrepresentation in applying for coverage or in receiving or filing for benefits.

(j) A carrier shall not retroactively adjust a claim based on eligibility if the provision of benefits is a required policy provision pursuant to section 10-16-202 (4) or 10-16-214 (3), unless the policyholder notified the carrier of an individual's ineligibility pursuant to section 10-16-103.5 (1).

(k) Nothing in this subsection (4.5) shall be construed to require a grace period for the payment of premiums to a health maintenance organization.

(l) (I) Any adjustment made by the carrier that recovers carrier overpayments to a provider shall include a written notice to the provider and shall contain a complete and specific explanation of such adjustments and information regarding the carrier's provider dispute resolution procedures pursuant to section 10-16-705 (13). Such notice shall be made to both the provider and the enrollee to the extent that the adjustment will result in enrollee liability. Notice to the enrollee required by this paragraph (l) shall include information regarding the carrier's enrollee appeals procedure rather than the carrier's provider dispute resolution procedures.

(II) (A) For claims adjusted by the carrier due to coordination of benefits, in addition to the requirements of this paragraph (l), upon request of the provider, the carrier shall provide all available information regarding the party responsible for payment of the claim to the provider.

(B) The carrier shall provide notice to the provider with the explanation of benefits regarding the availability of the information related to the party responsible for payment of the claim.

(m) Adjustments to claims made in cases where a carrier, pursuant to section 10-1-128 (5)(a)(IV), has reported fraud or abuse committed by the provider, shall not be subject to the requirements of this subsection (4.5).

(5) A managed care plan shall not deny benefits for emergency services previously rendered, based upon the covered person's failure to provide subsequent notification in accordance with plan provisions, where the covered person's medical condition prevented timely notification.

(5.5) (a) Notwithstanding any provision of law, a carrier that provides any benefits with respect to emergency services shall cover the emergency services:

(I) Without the need for any prior authorization determination;

(II) Regardless of whether the health-care provider furnishing emergency services is a participating provider with respect to emergency services;

(III) For services provided out of network;

(IV) Without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; and

(V) At the in-network benefit level, with the same coinsurance, deductible, or copayment requirements as would apply if the emergency services were provided by an in-network provider or at an in-network facility, and at no greater cost to the covered person than if the emergency services were obtained from an in-network provider at an in-network facility. Any payment made by a covered person pursuant to this subsection (5.5)(a)(V) must be applied to the covered person's in-network deductibles and in-network out-of-pocket maximum amounts and in the

same manner as if the cost-sharing payments were made to an in-network provider or an in-network facility.

(a.5) (I) A carrier shall:

(A) Cover post-stabilization services provided by an out-of-network provider or at an out-of-network facility at no greater cost to the covered person than the cost that would apply, and with the same coinsurance, deductible, or copayment requirements as the requirements that would apply, if the post-stabilization services were obtained from an in-network provider or at an in-network facility; and

(B) Reimburse the out-of-network provider for post-stabilization services in accordance with subsection (3)(d)(II) of this section and the out-of-network facility in accordance with subsection (5.5)(b) of this section.

(II) Any payment made by a covered person pursuant to subsection (5.5)(a.5)(I) of this section must be applied to the covered person's in-network deductibles and in-network out-of-pocket maximum amounts.

(b) (I) If a covered person receives emergency services at an out-of-network facility, other than any out-of-network facility operated by the Denver health and hospital authority pursuant to article 29 of title 25, the carrier shall reimburse the out-of-network provider in accordance with subsection (3)(d)(II) of this section and reimburse the out-of-network facility directly in accordance with section 10-16-106.5 the greater of:

(A) One hundred five percent of the carrier's median in-network rate of reimbursement for that service provided in a similar facility or setting in the same geographic area; or

(B) The median in-network rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado all-payer health claims database created in section 25.5-1-204.

(II) If a covered person receives emergency services at any out-of-network facility operated by the Denver health and hospital authority created in section 25-29-103, the carrier shall reimburse the out-of-network facility directly in accordance with section 10-16-106.5 the greater of:

(A) The carrier's median in-network rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area;

(B) Two hundred fifty percent of the medicare reimbursement rate for the same service provided in a similar facility or setting in the same geographic area; or

(C) The median in-network rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado all-payer health claims database described in section 25.5-1-204.

(III) Payment made by a carrier in compliance with this subsection (5.5)(b) is presumed to be payment in full for the services provided, except for any coinsurance, deductible, or copayment amount required to be paid by the covered person.

(c) This subsection (5.5) does not preclude the carrier and the out-of-network facility and the carrier and the provider from voluntarily negotiating an independent reimbursement rate. If the negotiations fail, the reimbursement rate required by subsection (5.5)(b) of this section applies.

(d) (I) Subsections (5.5)(a), (5.5)(b), and (5.5)(c) of this section do not apply to service agencies, as defined in section 25-3.5-103 (11.5), providing ambulance services, as defined in section 25-3.5-103 (3).

(II) (A) The commissioner shall promulgate rules to identify and implement a payment methodology that applies to service agencies described in subsection (5.5)(d)(I) of this section, except for service agencies that are publicly funded fire agencies.

(B) The commissioner shall make the payment methodology available to the public on the division's website. The rules must be equitable to service agencies and carriers; hold consumers harmless except for any applicable coinsurance, deductible, or copayment amounts; and be based on a cost-based model that includes direct payment to service agencies as described in subsection (5.5)(d)(I) of this section.

(C) The division may contract with a neutral third-party that has no financial interest in providers, emergency service providers, or carriers to conduct the analysis to identify and implement the payment methodology.

(e) Repealed.

(6) The carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to covered persons and shall only market a network plan in a geographic area where network providers are accessible without unreasonable delay. In determining whether a health carrier has complied with this subsection (6), consideration shall be given to the relative availability of health-care providers in the service area under consideration.

(7) A carrier shall monitor, on an ongoing basis, the capacity and legal authority of the participating providers and facilities with which it contracts to furnish all covered benefits to covered persons.

(8) No managed care plan shall deny or restrict in-network covered benefits to a covered person solely because the covered person obtained treatment outside the network. This protection shall be disclosed in writing to the covered person. Nothing in this subsection (8) shall be construed to require a managed care plan to pay for any benefit obtained outside the plan's network unless the contract or certificate provides for that out-of-network benefit.

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

(a) An adequate number of accessible acute care hospital services, within a reasonable distance or travel time, or both;

(a.3) An adequate number of accessible primary care providers within a reasonable distance or travel time, or both;

(a.5) An adequate number of accessible specialists and sub-specialists within a reasonable distance or travel time, or both, or who may be available through the use of telehealth;

(a.7) Geographic accessibility, which in some circumstances may require the crossing of county or state lines;

(a.9) If the covered person has a pharmacy benefit, an adequate number of pharmacy providers within a reasonable distance, travel time, delivery time, or all three. Nothing in this paragraph (a.9) shall preclude the use of a retail or mail-order pharmacy provider.

(b) A carrier offering a managed care plan shall maintain procedures for making referrals within and outside its network that, at a minimum, must include the following:

(I) A comprehensive listing, made available to covered persons and primary care providers, of the plan's network participating providers and facilities;

(II) (A) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a health maintenance organization may offer variable deductibles and copayments to encourage the selection of certain providers.

(B) A health maintenance organization that offers variable deductibles and copayments shall provide adequate and clear disclosure, as required by law, of variable deductibles and copayments to enrollees, and the amount of any deductible or copayment shall be reflected on the benefit card provided to the enrollees.

(III) Timely referrals for access to specialty care;

(IV) A process for expediting the referral process when indicated by medical condition; and

(V) (A) A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse;

(B) A provision that referrals approved by the plan cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse.

(c) The carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health-care needs of populations that enroll in managed care plans;

(d) The carrier's quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care;

(e) The carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(f) The carrier's methods for determining the health-care needs of covered persons, tracking and assessing clinical outcomes from network services, and evaluating consumer satisfaction with services provided;

(g) The carrier's method for informing covered persons of the plan's services and features, including but not limited to the following:

(I) The plan's grievance procedures, which shall be in conformance with division rules concerning prompt investigation of health claims involving utilization review and grievance procedures;

(II) The extent to which specialty medical services, including physical therapy, occupational therapy, and rehabilitation services are available;

(III) The plan's process for choosing and changing network providers; and

(IV) The plan's procedures for providing and approving emergency and medical care;

(h) The carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers;

(i) The carrier's process for enabling covered persons to change primary care professionals;

(j) The carrier's proposed plan for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination or the carrier's insolvency or other cessation of operations and transferred to other providers in a timely manner.

(k) Any other information required by the commissioner to determine compliance with the provisions of this part 7.

(10) (a) In determining the reasonableness of travel time and distances for the purposes of this section, consideration shall be given to differences in travel times for rural areas as opposed to urban areas, the relative availability of health-care providers, the location where the majority of people in the area access nonemergency services, and the managed care plan's good faith efforts to contract with local providers at reasonable rates.

(b) The commissioner, upon the commissioner's authority or upon review of one or more complaints, may require the carrier to demonstrate the adequacy of the network's plan as specified in subsection (9) of this section.

(c) The commissioner may utilize the remedies outlined in section 10-3-1108 for failing to provide proper disclosures to covered persons pursuant to subsection (2) or (2.5) of this section.

(11) The division of insurance, in cooperation with the chief medical officer for the state, shall evaluate a carrier's network adequacy plan concerning the use of telehealth for providers who are specialists and sub-specialists for rural areas. The division and chief medical officer shall conduct the review in a timely fashion so as not to delay access to health-care services.

(12) (a) On and after January 1, 2020, carriers shall develop and provide disclosures to covered persons about the potential effects of receiving emergency or nonemergency services from an out-of-network provider or at an out-of-network facility. The disclosures must, at a minimum, comply with the federal "No Surprises Act" and the rules adopted under subsection (12)(b) of this section.

(b) The commissioner, in consultation with the state board of health created in section 25-1-103 and the applicable regulators of health-care occupations and professions, shall adopt rules to specify the list of the ancillary services for which an out-of-network provider or out-of-network facility must not balance bill a covered person and the disclosure requirements under this subsection (12).

(c) Receipt of the disclosures required by this subsection (12) does not waive a covered person's protections under subsection (3) or (5.5) of this section or the right to benefits under the health benefit plan at the in-network benefit level for all covered services and treatment received.

(13) (a) When a carrier makes a payment to a provider or a health-care facility pursuant to subsection (3)(d) or (5.5)(b) of this section, the provider or the facility may request, and the commissioner shall collect, data from the carrier to evaluate the carrier's compliance in paying the highest rate required. The information requested may include the methodology for

determining the carrier's median in-network rate or reimbursement for each service in the same geographic area.

(b) Repealed.

(14) Repealed.

(15) (a) (I) If a provider or a health-care facility believes that a payment made pursuant to subsection (3) or (5.5) of this section or section 12-30-113 or a health-care facility believes that a payment made pursuant to subsection (5.5) of this section or section 25-3-122 (3) was not sufficient given the complexity and circumstances of the services provided, the provider or the health-care facility may initiate arbitration by filing a request for arbitration with the commissioner and the carrier. A provider or health-care facility must submit a request for the arbitration of a claim within ninety days after the receipt of payment for that claim.

(II) Prior to arbitration under subsection (15)(a)(I) of this section, if requested by the carrier and the provider or health-care facility, the commissioner may arrange an informal settlement teleconference to be held within thirty days after the request for arbitration. The parties shall notify the commissioner of the results of the settlement conference.

(III) Upon receipt of notice that the settlement teleconference was unsuccessful, the commissioner shall appoint an arbitrator and notify the parties of the arbitration.

(b) The commissioner shall promulgate rules to implement an arbitration process that establishes a standard arbitration form and includes the selection of an arbitrator from a list of qualified arbitrators developed pursuant to the rules. Qualified arbitrators must be independent; not be affiliated with a carrier, health-care facility, or provider, or any professional association of carriers, health-care facilities, or providers; not have a personal, professional, or financial conflict with any parties to the arbitration; and have experience in health-care billing and reimbursement rates.

(c) Within thirty days after the commissioner appoints an arbitrator and notifies the parties of the arbitration, both parties shall submit to the arbitrator, in writing, each party's final offer and each party's argument. The arbitrator shall pick one of the two amounts submitted by the parties as the arbitrator's final and binding decision. The decision must be in writing and made within forty-five days after the arbitrator's appointment. In making the decision, the arbitrator shall consider the circumstances and complexity of the particular case, including the following areas:

(I) The provider's level of training, education, experience, and specialization or subspecialization; and

(II) The previously contracted rate, if the provider had a contract with the carrier that was terminated or expired within one year prior to the dispute.

(d) If the arbitrator's decision made pursuant to subsection (15)(c) of this section requires additional payment by the carrier above the amount paid, the carrier shall pay the provider in accordance with section 10-16-106.5. A carrier shall not recalculate a covered person's cost-sharing amount based on an additional payment required or made as a result of an arbitration decision.

(e) The party whose final offer amount was not selected by the arbitrator shall pay the arbitrator's expenses and fees. If the parties reach a settlement after an arbitrator is appointed but before the arbitrator makes a final decision, the parties shall split the costs of the arbitration equally unless otherwise agreed by the parties.

(16) Repealed.

(17) The commissioner shall post on the division's website information on the state and federal agencies that a covered person may contact if a provider, facility, or carrier violates this section.

(18) The commissioner may adopt rules to implement this section, including rules necessary to implement the requirements of the federal "No Surprises Act".

(19) As used in this section:

(a) "Ancillary services" means:

(I) Diagnostic services, including radiology and laboratory services, unless excluded by rule of the secretary of the United States department of health and human services pursuant to 42 U.S.C. sec. 300gg-132 (b)(3);

(II) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or nonphysician provider, unless excluded by rule of the secretary of the United States department of health and human services pursuant to section 2799B-2 (b)(3) of the federal "No Surprises Act";

(III) Items and services provided by assistant surgeons, hospitalists, and intensivists, unless excluded by rule of the secretary of the United States department of health and human services pursuant to section 2799B-2 (b)(3) of the federal "No Surprises Act";

(IV) Items and services provided by an out-of-network provider if there is no in-network provider who can furnish the needed services at the facility; and

(V) Any other items and services provided by specialty providers as established by rule of the commissioner.

(b) "Applicable regulators of health-care occupations and professions" means the:

(I) Colorado state board of chiropractic examiners created in section 12-215-104;

(II) Colorado dental board created in section 12-220-105;

(III) Colorado medical board created in section 12-240-105;

(IV) State board of psychologist examiners created in section 12-245-302;

(V) State board of social work examiners created in section 12-245-402;

(VI) State board of marriage and family therapist examiners created in section 12-245-502;

(VII) State board of licensed professional counselor examiners created in section 12-245-602;

(VIII) State board of unlicensed psychotherapists created in section 12-245-702;

(IX) State board of addiction counselor examiners created in section 12-245-802;

(X) State board of nursing created in section 12-255-105;

(XI) Board of examiners of nursing home administrators created in section 12-265-106;

(XII) State board of optometry created in section 12-275-107;

(XIII) State board of pharmacy created in section 12-280-104;

(XIV) State physical therapy board created in section 12-285-105;

(XV) Colorado podiatry board created in section 12-290-105; and

(XVI) The director of the division of professions and occupations in the department of regulatory agencies.

(c) "Balance bill" means:

(I) The amount that an out-of-network provider may charge a covered person for the provision of health-care services, which amount equals the difference between the amount paid

by the carrier for the health-care services and the amount of the out-of-network provider's billed charge for the health-care services; and

(II) The act of a nonparticipating provider charging a covered person the difference between the billed amount and the amount the carrier paid the provider.

(d) "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:

(I) Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or unborn child;

(II) Serious impairment to bodily functions; or

(III) Serious dysfunction of any bodily organ or part.

(e) (I) "Emergency services", with respect to an emergency medical condition, means:

(A) A medical screening examination that is within the capability of the emergency department of a hospital or a freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(B) Within the capabilities of the staff and facilities available at the hospital, regardless of the department in which further examination or treatment is furnished, or the freestanding emergency department, as applicable, further medical examination and treatment as are required to stabilize the patient to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility.

(II) For a covered person who is provided services described in subsections (19)(e)(I)(A) and (19)(e)(I)(B) of this section with respect to an emergency medical condition, unless each of the conditions in subsection (19)(e)(III) of this section are met, the term "emergency services" includes services that are:

(A) Covered under the health benefit plan; and

(B) Provided by a nonparticipating provider or nonparticipating emergency facility, regardless of the department or the facility in which the items or services are provided, after the covered person is stabilized and as part of the outpatient observation or inpatient or outpatient stay, with respect to the emergency visit in which the services described in subsection (19)(e)(I) of this section are provided.

(III) For the purposes of subsection (19)(e)(II) of this section, the conditions described in this subsection (19)(e)(III), with respect to a covered individual who is stabilized and furnished additional items and services described in subsection (19)(e)(II) of this section after the stabilization by a provider or facility are the following:

(A) The out-of-network provider or out-of-network facility determines the covered person is able to travel using nonmedical transportation or nonemergency medical transportation;

(B) The out-of-network provider or out-of-network facility has provided the covered person with notice and obtained consent as required by section 12-30-112 or 25-3-121, as applicable;

(C) The covered person is in a condition to receive the notice and consent described in section 12-30-112 or 25-3-121 and to provide informed consent; and

(D) The out-of-network provider or out-of-network facility is in compliance with, at a minimum, other requirements established in 42 U.S.C. sec. 300gg-111 and any federal regulations adopted pursuant to 42 U.S.C. sec. 300gg-111.

(f) "Federal 'No Surprises Act'" means the federal "No Surprises Act", Pub.L. 116-260, as amended.

(g) "Freestanding emergency department" has the same meaning as set forth in section 25-1.5-114 (5).

(h) "Geographic area" means a specific area in this state as established by the commissioner by rule.

(i) "In-network facility" means a participating provider that is a health-care facility.

(j) "In-network provider" means a participating provider who is an individual.

(k) "Medicare reimbursement rate" means the reimbursement rate for a particular health-care service provided under the "Health Insurance for the Aged Act", Title XVIII of the federal "Social Security Act", 42 U.S.C. sec. 1395 et seq., as amended.

(l) "Negotiated rate" means the rate mutually agreed upon between the carrier and the provider in a specific instance.

(m) "Stabilized" means the condition of a patient in which, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from one facility or department to another.

(n) "Usual, customary, and reasonable rate" means a rate established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.

Source: L. 97: Entire part added, p. 1325, § 2, effective July 1. **L. 2001:** (1), (2), IP(9), (9)(a), IP(9)(b), and (9)(b)(V) amended and (2.5), (2.7), (9)(a.3), (9)(a.5), (9)(a.7), (9)(a.9), (10), and (11) added, pp. 1154, 1158, §§ 4, 5, effective January 1, 2002. **L. 2002:** (1)(c), (9)(a.7), and (9)(b)(II) amended and (2)(g) to (2)(l) added, pp. 1296, 1297, §§ 12, 13, effective January 1, 2003; (4.5) added, p. 884, § 1, effective January 1, 2003. **L. 2003:** (4.5)(m) amended, p. 618, § 20, effective July 1. **L. 2006:** (3) amended, p. 1566, § 1, effective June 2; (2)(m) added, p. 588, § 1, effective September 1. **L. 2010:** (3)(c) repealed, (SB 10-183), ch. 308, p. 1452, § 1, effective May 27. **L. 2013:** (1.5) and (5.5) added and (2)(g)(III) amended, (HB 13-1266), ch. 217, p. 982, § 36, effective May 13. **L. 2015:** (1)(a), (9)(a.5), and (11) amended, (HB 15-1029), ch. 38, p. 96, § 3, effective January 1, 2017. **L. 2017:** (1.5)(a)(II) amended, (SB 17-249), ch. 283, p. 1550, § 21, effective June 1. **L. 2019:** (4.5)(f) and (4.5)(j) amended, (SB 19-041), ch. 85, p. 301, § 2, effective August 2; IP(2)(b)(II), (2)(b)(II)(B), and (2)(l) amended, (HB 19-1172), ch. 136, p. 1658, § 55, effective October 1; (3)(a)(III), IP(5.5)(a), (5.5)(a)(V), and (5.5)(b) amended and (3)(d), (5.5)(c), (5.5)(d), (5.5)(e), and (12) to (16) added, (HB 19-1174), ch. 171, p. 1983, § 4, effective January 1, 2020. **L. 2022:** (2)(f), (3)(a)(IV), (3)(d)(VI), and (5.5)(e) repealed, (3)(b), (3)(d)(V), (5.5)(a)(V), (12)(a), (12)(b), (13), (14), (15)(d), and (15)(e) amended, and (5.5)(a.5), (17), (18), and (19) added, (HB 22-1284), ch. 446, p. 3133, § 2, effective August 10. **L. 2024:** (14) and (16) repealed, (SB 24-135), ch. 34, p. 105, § 2, effective March 22.

Editor's note: Subsection (13)(b)(III) provided for the repeal of subsection (13)(b), effective July 31, 2023. (See L. 2022, p. 3133.)

Cross references: For the legislative declaration contained in the 2001 act amending subsections (1), (2), (9)(a), and (9)(b)(V) and the introductory portions to subsections (9) and (9)(b) and enacting subsections (2.5), (2.7), (9)(a.3), (9)(a.5), (9)(a.7), (9)(a.9), (10), and (11), see section 1 of chapter 300, Session Laws of Colorado 2001.

10-16-705. Requirements for carriers and participating providers - definitions - rules. (1) In addition to any other applicable requirements of this part 7, a carrier offering a managed care plan shall satisfy all the requirements of this section.

(2) A carrier shall maintain a mechanism by which providers can access information on the covered health services for which the provider is responsible, including any limitations or conditions on services.

(3) Every contract between a carrier and a participating provider shall set forth a hold harmless provision specifying that covered persons shall, in no circumstances, be liable for money owed to participating providers by the plan and that in no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the carrier. Nothing in this section shall prohibit a participating provider from collecting coinsurance, deductibles, or copayments as specifically provided in the covered person's contract with the managed care plan.

(4) (a) Every contract between a carrier and a participating provider shall include provisions for continuity of care as specified in this subsection (4).

(b) Each carrier that issues a managed care plan shall allow covered persons to continue receiving care for up to ninety days after the date a carrier has provided notice to an individual enrolled in such plan pursuant to subsection (4)(d)(II)(A) of this section that the contract is terminated. The carrier shall provide the requisite coverage or continuing care to the covered person at the covered person's in-network benefit level cost-sharing amount during the period beginning on the date on which the notice of termination is given pursuant to subsection (4)(d)(II)(A) of this section and ending on the earlier of the ninety-day period beginning on such date or the date on which the covered person is no longer a continuing care patient with the provider or health-care facility.

(c) In the circumstance that coverage is terminated for any reason other than nonpayment of the premium, fraud, or abuse, every managed care plan shall provide for continued care for covered persons being treated at an in-patient facility until the patient is discharged.

(d) (I) A carrier shall comply with the requirements of subsection (4)(d)(II) of this section if a participating provider, whether an individual provider or a facility, is treating a continuing care patient who is a covered person under the plan and if:

(A) The contract between the carrier and the participating provider is terminated due to the expiration or nonrenewal of the contract;

(B) The benefits provided under the managed care plan or the health insurance coverage, with respect to the provider or facility, are terminated due to the expiration or nonrenewal of the contract between the carrier and the provider or facility because of a change in the terms of the participation in the plan or coverage; or

(C) A contract between the group health plan and the carrier offering coverage in connection with the group health plan is terminated due to the expiration or nonrenewal of the contract, resulting in the loss of benefits under the plan with respect to the participating provider

that is providing treatment or services to the covered person in compliance with the federal "No Surprises Act".

(II) A carrier subject to this subsection (4)(d) shall:

(A) Notify each covered person who is receiving care from a provider or facility with whom a contract is terminated as described in subsection (4)(d)(I) of this section, at the time of the termination of the contract, that the patient has the right to elect continued transitional care from the treating provider or facility if the termination of the contract affects the status of the provider or facility as a participating provider;

(B) Provide the covered person with an opportunity to notify the managed care plan or carrier of the need for transitional care; and

(C) Permit the covered person to elect to continue to have benefits provided under the covered person's current plan or coverage under the same terms and conditions as would have applied and with respect to the same items and services as would have been covered had a termination described in subsection (4)(d)(I) of this section not occurred, with respect to the course of treatment furnished by the provider or facility relating to the covered person's status as a continuing care patient during the period beginning on the date on which the notice under subsection (4)(d)(II)(A) of this section is provided and ending on the ninety-first day after that date or the date on which the covered person is no longer a continuing care patient with respect to the provider or facility, whichever is earlier.

(III) As used in this subsection (4)(d):

(A) "Continuing care patient" means a covered person who, with respect to a provider or facility whose contract with the covered person's carrier is terminated: Is undergoing a course of treatment for a serious and complex medical condition, which course of treatment is provided by the provider or facility; is undergoing a course of inpatient care provided by the provider or facility; is pregnant and undergoing a course of treatment for the pregnancy provided by the provider or facility; is terminally ill as determined under section 1861 (dd)(3)(A) of the federal "Social Security Act", as amended, and is receiving treatment for the illness from the provider or facility; or is scheduled to undergo nonelective surgery from the provider or facility, including the receipt of postoperative care from the provider or facility with respect to the surgery.

(B) "Serious and complex medical condition" means, in the case of acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.

(C) "Terminated", with respect to a contract, means the expiration or nonrenewal of the contract; except that "terminated" does not include a contract terminated for failure to meet applicable quality standards or for fraud.

(4.5) (a) As used in this subsection (4.5):

(I) "Facility" means a health-care facility licensed or certified pursuant to section 25-1.5-103.

(II) "Medicaid" means a medical assistance program established pursuant to the "Colorado Medical Assistance Act", articles 4 to 6 of title 25.5.

(III) "Serious and complex medical condition" has the same meaning as set forth in subsection (4)(d)(III)(B) of this section.

(IV) "Transferring enrollee" means an individual who:

(A) Was enrolled in medicaid or the children's basic health plan but is no longer eligible for benefits through the program in which the individual was enrolled; or

(B) Was covered under a health benefit plan whose coverage has not been renewed because the carrier is no longer offering any health benefit plans that the individual is eligible for and is therefore enrolled in a new health benefit plan and who: Is undergoing a course of treatment for a serious and complex medical condition that is treated by the provider or facility; is undergoing a course of inpatient care provided by the provider or facility; is pregnant and undergoing a course of treatment for the pregnancy provided by the provider or facility; is terminally ill as determined under section 1861 (dd)(3)(A) of the federal "Social Security Act", 42 U.S.C. sec. 1395x, as amended, and is receiving treatment for the illness from the provider or facility; or is scheduled to undergo nonelective surgery from the provider or facility, including the receipt of postoperative care from the provider or facility with respect to the surgery.

(b) A carrier shall allow a transferring enrollee to continue to receive treatment as an in-network benefit from an out-of-network provider or facility as follows:

(I) A transferring enrollee being treated by an out-of-network provider or facility may continue to receive treatment from that provider or facility until the current episode of treatment ends or until ninety days after the enrollee is covered by a new health benefit plan, whichever occurs first.

(II) A transferring enrollee who is pregnant and being treated by an out-of-network provider or facility may continue to receive treatment through the completion of postpartum care, beginning on the date of the enrollee's first day as a covered person under a new health benefit plan.

(c) (I) During the time periods covered under subsection (4.5)(b) of this section:

(A) A carrier shall reimburse the out-of-network provider or facility at the carrier's standard in-network reimbursement rate; and

(B) The carrier may require the out-of-network provider or facility to adhere to the carrier's terms and conditions, quality of care standards and protocols, referral process, and reporting standards that apply to comparable in-network providers or facilities in order for the out-of-network provider or facility to be eligible for reimbursement under subsection (4.5)(c)(I)(A) of this section.

(II) If an out-of-network provider or facility has been reimbursed pursuant to subsection (4.5)(c)(I)(A) of this section, the transferring enrollee shall not be balance billed.

(d) This subsection (4.5) does not require a provider or facility to continue to provide care for a transferring enrollee after the applicable time period in subsection (4)(b) of this section.

(e) A carrier subject to this subsection (4.5) shall:

(I) Notify the transferring enrollee, in plain language, at the time of enrollment that the enrollee has the right to elect continued transitional care from an out-of-network provider or facility if the enrollee is a transferring enrollee; and

(II) At the request of the transferring enrollee or the enrollee's provider, grant the transferring enrollee an opportunity to notify the carrier of the need for continued transitional care within one month after the transferring enrollee's effective date of coverage.

(f) (I) At the request of the transferring enrollee or provider, a new carrier shall accept a preauthorization for treatment from the previous carrier for coverage by the new carrier or from the department of health care policy and financing for:

(A) The procedures, treatment, medications, or services that are covered benefits under the new health benefit plan; and

(B) A period of ninety days or for the course of treatment, whichever is less, or until the completion of postpartum care.

(II) Subject to state and federal laws relating to the confidentiality of medical records, at the request and with the consent of an enrollee, a carrier shall provide a copy of the enrollee's preauthorization for treatment to the enrollee's new carrier within ten days after receipt of the request.

(III) After the applicable time period under subsection (4.5)(b) of this section has lapsed, the new carrier may elect to perform its own utilization review in order to:

(A) Reassess and make its own determination regarding the need for continued treatment; and

(B) Authorize any continued procedure, treatment, medication, or service deemed to be medically necessary.

(g) This subsection (4.5) does not require a carrier to provide benefits to an enrollee that are not otherwise covered benefits under the health benefit plan.

(h) The commissioner may adopt rules to implement this subsection (4.5).

(5) (a) Except as provided for in paragraph (b) of this subsection (5), notwithstanding any contractual provision to the contrary, a carrier that has entered into contracts with one or more contractors or subcontractors or their intermediaries to provide covered health-care services to covered persons of the carrier under any managed care plan shall, in the event of nonpayment by, or insolvency of, such contractors or subcontractors or their intermediaries, remain responsible for the payment of all participating providers that have provided covered health-care services to covered persons of the carrier pursuant to one or more contracts with such contractors or subcontractors or their intermediaries. Any contracting provider that provides covered health-care services to covered persons of the carrier under a managed care contract shall, in the event of nonpayment for such services, have legal standing to enforce the managed care contract against the carrier and receive payment for such services. In the event of the insolvency of a carrier, participating provider claims for unpaid services shall be a class 6 claim under section 10-3-541 (1)(f).

(b) A carrier may apply to the commissioner for the use of an alternative mechanism to ensure that all participating providers that have provided covered health-care services to covered persons of the carrier pursuant to one or more contracts with such contractors or subcontractors or their intermediaries receive payment due. If approval is granted, said carrier shall be exempt from the requirements of paragraph (a) of this subsection (5).

(6) A carrier shall notify participating providers of the providers' responsibilities with respect to the carrier's applicable administrative policies and programs, including but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs.

(6.5) A carrier that has entered into a contract with one or more intermediaries to conduct utilization management, utilization review, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, or disease management programs shall require the intermediary to comply with the same standards, guidelines, medical policies, and benefit terms of the carrier.

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

(8) The rights and responsibilities under a contract between a carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the carrier, and any subcontracts shall comply with the requirements of this part 7.

(9) A carrier's contract with participating providers shall include a provision that participating providers do not discriminate, with respect to the provision of medically necessary covered benefits, against covered persons that are participants in a publicly financed program.

(9.5) If the health benefit plan provides coverage for a second opinion, the carrier and any entity that contracts with the carrier shall disclose the availability of the second opinion along with the health benefit description form.

(10) A carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for noncovered services.

(10.5) (a) A carrier that has entered into a contract with one or more intermediaries to conduct utilization management, utilization review, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, or disease management programs, shall require the intermediary to indicate the name of the intermediary and the name of the carrier for which it is conducting the work when making any payment to a health-care provider on behalf of the carrier.

(b) (I) A violation of subsection (6.5) of this section or this subsection (10.5) is an unfair or deceptive act or practice in the business of insurance pursuant to section 10-3-1104.

(II) The commissioner may examine the actions of a carrier pursuant to subsection (6.5) of this section and this subsection (10.5) when conducting a market conduct analysis pursuant to part 2 of article 1 of this title.

(11) A carrier shall not penalize a provider because the participating provider, in good faith, reports to state or federal authorities any act or practice by the carrier that jeopardizes patient health or welfare, or because the participating provider discusses the financial incentives or financial arrangements between the provider and the managed care plan.

(11.5) A carrier or entity that contracts with the carrier shall not penalize a primary care provider who makes a standing referral of a covered person to a specialist, nor shall the specialist treating the covered person be penalized, with actions that include but are not limited to disincentives or disaffiliation, except for violations of section 10-1-128.

(12) (a) A carrier shall establish one or more mechanisms by which the participating providers may determine, at the time services are provided, whether or not a person is covered by the carrier or is within the grace period established under section 10-16-140 (1), during which

period a carrier may hold a claim for services pending receipt of full premium payment. If a carrier maintains only one mechanism, such mechanism shall not require electronic access.

(b) (I) Each carrier, regardless of the mechanism used, shall issue a verification code that the participating provider may use as proof of verification as required by section 10-16-704 (4.5)(f).

(II) In lieu of the requirements of this paragraph (b), for the purposes of verifying the carrier's communication to the provider pursuant to section 10-16-704 (4.5)(g) or (4.5)(h), a carrier may submit written confirmation to a provider within two business days.

(III) If a carrier provides electronic access as a mechanism to verify coverage, the carrier may, in lieu of the requirement to issue a verification code through such mechanism, accept as proof of verification a dated screen print from the carrier's electronic verification mechanism demonstrating that the member is eligible pursuant to section 10-16-704 (4.5)(g) or that the carrier is not required to pay for services pursuant to section 10-16-704 (4.5)(h).

(c) In lieu of the requirements of paragraph (b) of this subsection (12), a carrier may institute a policy providing that adjustments to claims related to eligibility will be made only if the carrier can demonstrate that the member did not appear as eligible on any of the carrier's verification mechanisms on the date of service.

(d) A carrier shall notify participating providers of the mechanisms available to verify eligibility and the carrier's intent with respect to the requirements of paragraphs (a), (b), and (c) of this subsection (12).

(13) A carrier shall establish procedures for resolution of administrative, payment, or other disputes between providers and the carrier.

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

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

(b) A provision that allows a covered person to receive a standing referral for medically necessary treatment to a specialist or specialized treatment center participating in the carrier's network or participating in a subdivision or subgrouping of the carrier's network if the subdivision or subgrouping demonstrates network adequacy pursuant to section 10-16-704. The primary care provider for the covered person, in consultation with the specialist and covered person, shall determine that the covered person needs ongoing care from the specialist in order to make the standing referral. A time period for the standing referral of up to one year, or a longer period of time if authorized by the carrier or any entity that contracts with the carrier, shall be determined by the primary care provider in consultation with the specialist or specialized treatment center. The specialist or specialized treatment center shall refer the covered person back to the primary care provider for primary care. To be reimbursed by the carrier or entity contracting with a carrier, treatment provided by the specialist shall be for a covered person and must comply with provisions contained in the covered person's certificate or policy. The primary care physician shall record the reason, diagnosis, or treatment plan necessitating the standing referral.

(15) A contract between a carrier and a participating provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this part 7.

(16) A provider who is not licensed to furnish health-care services in this state and who participates in a network shall be licensed in the state in which the provider practices and shall meet minimum statutory and regulatory standards for that professional practice applicable in this state.

Source: L. 97: Entire part added, p. 1328, § 2, effective July 1. **L. 99:** (9.5) and (11.5) added and (14) amended, p. 318, § 2, effective July 1. **L. 2002:** (12) amended, p. 886, § 2, effective January 1, 2003; (16) added, p. 1299, § 14, effective January 1, 2003. **L. 2003:** (11.5) and (12)(b)(I) amended, p. 618, § 21, effective July 1. **L. 2009:** (6.5) and (10.5) added, (HB 09-1061), ch. 197, p. 885, § 1, effective August 5. **L. 2013:** (12)(a) and (14)(b) amended, (HB 13-1266), ch. 217, p. 989, § 51, effective May 13. **L. 2022:** (4)(b) amended and (4)(d) added, (HB 22-1284), ch. 446, p. 3142, § 3, effective August 10. **L. 2024:** (4.5) added, (SB 24-093), ch. 41, p. 146, § 1, effective January 1, 2025.

Cross references: (1) For the federal "No Surprises Act", see Pub.L. 116-260.

(2) For the legislative declaration contained in the 1999 act adding subsections (9.5) and (11.5) and amending subsection (14), see section 1 of chapter 111, Session Laws of Colorado 1999.

10-16-705.5. Participating provider networks - definitions - selection standards - informal reconsideration - enforcement - legislative declaration. (1) The general assembly finds and declares that:

(a) Carriers create networks of providers that ensure consumers have access to an adequate number of providers to meet their needs;

(b) In the current marketplace, carriers offer consumers a multitude of plan options, some of which include a limited provider network that may result in a smaller number of participating providers from which to choose;

(c) Limited provider networks allow carriers and providers to work together to improve the quality of care and control the associated costs on behalf of consumers;

(d) Transparency in the market provides consumers, payers, and providers with information necessary to make informed decisions about health-care choices; and

(e) To ensure that consumers have sufficient access to care and appropriate, transparent information to make decisions related to their health care, carriers should:

(I) Disclose the standards used to construct their participating provider networks to the commissioner, providers, and consumers; and

(II) Provide a process for existing participating providers to seek reconsideration of a carrier's decision to change participation in a carrier's network, including tiering of a network.

(2) As used in this section, unless the context otherwise requires:

(a) "High-risk population" means a population presenting a risk of higher-than-average numbers of claims, losses, or health-care utilization rates.

(b) "Tiered network" means a network that identifies and assigns some or all types of providers and facilities into specific groups to which different provider reimbursement, covered

person cost sharing, or provider access requirements, or any combination of reimbursement, cost sharing, and access requirements, apply for the same service.

(3) (a) A carrier shall develop standards for the selection of providers in the carrier's participating provider network, including the selection of providers in each health-care specialty. If the carrier offers a tiered network, the carrier shall develop standards for tiering participating providers within the tiered network.

(b) The carrier and the carrier's intermediary shall use the standards developed pursuant to subsection (3)(a) of this section in selecting and tiering providers.

(c) (I) A carrier shall not establish selection and tiering criteria in a manner that would:

(A) Allow a carrier to discriminate against high-risk populations by excluding or tiering providers based on their location in a geographic area that contains high-risk populations; or

(B) Exclude providers because they treat or specialize in treating high-risk populations.

(II) Nothing in this subsection (3)(c) prohibits a carrier from offering specific networks or products that are limited to designated service areas.

(d) A carrier shall make all applicable standards used for selecting and tiering available for review by the commissioner and shall communicate the standards to providers that are participating in one or more of its networks. Additionally, a carrier shall make a description of its standards, in plain language, available to the public.

(4) Upon request, and not more often than quarterly, a carrier shall provide a provider that is participating in one or more of its networks with a complete list of all network plans and products the carrier offers to consumers, with an indication of the provider's participation status within each network plan or product. The carrier shall respond to a provider's request within thirty days after it receives the request.

(5) (a) A carrier shall neither terminate a participating provider nor place a participating provider in a tiered network without first complying with the requirements of this subsection (5).

(b) At least sixty days before terminating or placing a participating provider in a tiered network, the carrier shall send a written notice to the participating provider informing the participating provider of the pending action. The notice must:

(I) Contain an explanation of the reasons for the proposed action in sufficient detail to enable the participating provider to challenge the proposed action, referencing the relevant information the carrier is relying on for the determination;

(II) Inform the participating provider of the opportunity to request the carrier to reconsider the pending action and the period for completing the informal reconsideration process; and

(III) Inform the participating provider of the carrier's ability to rescind the pending action.

(c) A carrier shall establish procedures for a participating provider to request a carrier to reconsider its decision to terminate the participating provider or place the participating provider in a tiered network. The procedures must include:

(I) A reasonable method by which the participating provider may submit a request for the carrier to reconsider a proposed pending action, including the name of the person or division to whom or to which the participating provider is to submit the request; and

(II) An opportunity to submit or have the carrier consider evidence that may correct information relevant to the pending action.

(d) The carrier shall complete the informal reconsideration process within forty-five days after the date the carrier received the request for reconsideration from the participating provider unless the carrier and participating provider agree to an alternative deadline to complete the informal reconsideration process.

(e) A carrier shall not implement the pending action specific to the participating provider that is the subject of a request for reconsideration until the carrier issues a final decision to grant or deny the request to reconsider the pending action.

(6) When a carrier does not select a provider to participate in the carrier's participating provider network, the carrier shall provide a written notification to the provider. The carrier is not required to provide an opportunity for reconsideration to a provider who is not participating in any of the carrier's participating provider networks.

(7) This section does not:

(a) Prohibit a carrier from declining to select a provider who fails to meet other legitimate selection criteria developed by the carrier in compliance with this section;

(b) Prohibit a carrier from creating an exclusive provider network; or

(c) Require a carrier to contract with any provider who is willing to abide by the terms and conditions for participation established by the carrier.

(8) (a) If the commissioner determines that a carrier has not complied with this section, the commissioner shall require a corrective action plan that the carrier must follow. The commissioner may use all enforcement powers under this title 10 to obtain compliance by the carrier.

(b) The commissioner and the commissioner's staff shall not arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a network or tiered network or regarding any dispute between a carrier, the carrier's intermediary, or one or more providers arising under or by reason of a provider contract or its termination.

Source: L. 2017: Entire section added, (SB 17-088), ch. 135, p. 451, § 1, effective January 1, 2018.

10-16-705.7. Timely credentialing of physicians by carriers - notice of receipt required - notice of incomplete applications required - delegated credentialing agreements - discrepancies - denials of claims prohibited - disclosures - recredentialing - enforcement - rules - definitions. (1) As used in this section, unless the context otherwise requires:

(a) "Applicant" means a physician who submits an application to a carrier to become a participating physician in the carrier's network.

(b) "Application" means an applicant's application to become credentialed by a carrier as a participating physician in at least one of the carrier's provider networks.

(c) "Carrier credentialing alliance" means an organization of carriers that share activities or responsibilities pertaining to credentialing.

(d) "Credentialing" or "credential" means the process by which a carrier or its designee collects information concerning an applicant; assesses whether the applicant satisfies the relevant licensing, education, and training requirements to become a participating physician; verifies the assessment; and approves or disapproves the applicant's application.

(e) "Delegated credentialing agreement" means an agreement between a carrier and a designee by which the carrier delegates to the designee activities or responsibilities pertaining to credentialing.

(f) "Designee" means a third party to which a carrier delegates activities or responsibilities pertaining to credentialing.

(g) "Health-care facility" means a facility licensed or certified by the department of public health and environment pursuant to section 25-1.5-103.

(h) "Participating physician" means a physician who is credentialed by a carrier or its designee to provide health-care items or services to covered persons in at least one of the carrier's provider networks.

(i) "Physician" means a physician who is licensed pursuant to article 240 of title 12.

(j) "Recredentialing" or "recredential" means the process by which a carrier or its designee confirms that a participating physician is in good standing and continues to satisfy the carrier's requirements for participating physicians.

(2) (a) Within seven calendar days after a carrier receives an application, the carrier shall provide the applicant a receipt in written or electronic form.

(b) Upon receiving an application, a carrier shall promptly determine whether the application is complete. If the carrier determines that the application is incomplete, the carrier shall notify the applicant in writing or by electronic means that the application is incomplete within ten calendar days after the date the carrier received the application. The notice must describe the items that are required to complete the application.

(c) If a carrier receives a completed application but fails to provide the applicant a receipt in written or electronic form within seven calendar days after receiving the application, as required by subsection (2)(a) of this section, the carrier shall consider the applicant a participating physician, effective no later than fifty-three calendar days following the carrier's receipt of the application.

(3) (a) A carrier shall conclude the process of credentialing an applicant within sixty calendar days after the carrier receives the applicant's completed application.

(b) A carrier shall provide each applicant written or electronic notice of the outcome of the applicant's credentialing within ten calendar days after the conclusion of the credentialing process.

(c) After concluding the credentialing process for an applicant and making a determination regarding the applicant's application, a carrier shall provide to the applicant, at the applicant's request and as allowed by law, all nonproprietary information pertaining to the application and to the final decision regarding the application.

(4) Notwithstanding any other provision of this section:

(a) A carrier that enters into and complies with the requirements of a delegated credentialing agreement with a health-care facility, which agreement imposes equivalent or higher requirements than those described in this section, is deemed to be in compliance with the requirements of this section with regard to an applicant who works for that facility.

(b) A carrier that participates in and complies with the requirements of a carrier credentialing alliance that imposes equivalent or higher requirements than those described in this section is deemed to be in compliance with the requirements of this section.

(5) A carrier shall correct discrepancies in its provider or network directory within thirty calendar days after receiving a report of the discrepancy from a participating physician. A

participating physician shall notify a carrier of any change in the physician's name, address, telephone number, business structure, or tax identification number within fifteen business days after making the change.

(6) A carrier may not deny a claim for a medically necessary covered service provided to a covered person if the service:

(a) Is a covered benefit under the covered person's health coverage plan; and

(b) Is provided by a participating physician who is in the provider network for the carrier's health coverage plan and has concluded the carrier's credentialing process.

(7) A carrier shall make the following nonproprietary information available to all applicants and shall post the information on its website:

(a) The carrier's credentialing policies and procedures;

(b) A list of the information required to be included in an application;

(c) A checklist of materials that must be submitted in the credentialing process;

(d) Designated contact information, including a designated point of contact, an email address, and a telephone number, to which an applicant may address any credentialing inquiries; and

(e) The requirements described in subsection (2) of this section and the authority of the commissioner to enforce the requirements and impose penalties for violations, as described in subsection (10) of this section.

(8) (a) A carrier or its designee may recredential a participating physician if such recredentialing is:

(I) Required by federal or state law or by the carrier's accreditation standards; or

(II) Permitted by the carrier's contract with the participating physician.

(b) A carrier shall not require a participating physician to submit an application or participate in a contracting process in order to be recredentialed.

(c) Nothing in this subsection (8) affects the contract termination rights of a carrier or a participating physician.

(9) Except as described in subsection (8) of this section and as may be provided in a contract between a carrier and a participating physician, a carrier shall allow a participating physician to remain credentialed and include the participating physician in the carrier's health coverage plan provider network unless the carrier discovers information indicating that the participating physician no longer satisfies the carrier's guidelines for participation, in which case the carrier shall satisfy the requirements described in section 10-16-705 (5) before terminating the participating physician's participation in the provider network.

(9.5) A carrier shall not refuse to credential an applicant or terminate a participating physician's participation in a provider network based solely on the applicant's or participating physician's provision of, or assistance in the provision of, a legally protected health-care activity, as defined in section 12-30-121 (1)(d), in this state, so long as the care provided did not violate Colorado law.

(10) The commissioner shall enforce this section and may promulgate such rules as are necessary for the implementation of this section. Upon receiving more than one complaint from an applicant or a participating physician alleging a violation of this section by a carrier, the commissioner shall investigate the complaints. A carrier that fails to comply with this section or with any rules adopted pursuant to this section is subject to such civil penalties as the commissioner may order pursuant to section 10-1-310.

Source: L. 2021: Entire section added, (SB 21-126), ch. 443, p. 2929, § 1, effective September 7. **L. 2023:** (9.5) added, (SB 23-188), ch. 68, p. 242, § 4, effective April 14.

Cross references: For the legislative declaration in SB 23-188, see section 1 of chapter 68, Session Laws of Colorado 2023.

10-16-706. Intermediaries. (1) In addition to any other applicable requirements of this part 7, a contract between a carrier and an intermediary shall satisfy all the requirements of this section.

(2) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of section 10-16-705.

(3) The responsibility to ensure that participating providers have the capacity and legal authority to furnish covered benefits shall be retained by the carrier.

(4) A carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

(5) A carrier shall maintain copies of all intermediary health-care subcontracts.

(6) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the carrier. The carrier shall monitor the timeliness and appropriateness of payments made to participating providers and health-care services received by covered persons.

(7) If applicable, an intermediary shall maintain books, records, financial information, and documentation of services provided to covered persons at the intermediary's place of business in this state.

(8) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons as necessary to determine compliance with this part 7.

(9) A carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the carrier of the provisions of a participating provider's contract addressing the provider's obligation to furnish covered services.

Source: L. 97: Entire part added, p. 1331, § 2, effective July 1.

10-16-707. Enforcement. (1) If it is determined that a carrier has not contracted with enough participating providers to assure that covered persons have accessible health-care services in a geographic area, that a carrier's access plan does not assure reasonable access to covered benefits, that a carrier has entered into a contract that does not comply with this part 7, or that a carrier has not complied with a provision of this part 7, the commissioner may institute a corrective action that shall be followed by the carrier or may use any of the commissioner's other enforcement powers to obtain the carrier's compliance with this part 7.

(2) The commissioner shall not act to arbitrate, mediate, or settle disputes between a managed care plan and a provider concerning a provider's inclusion or termination from the network.

(3) Failure of a provider to comply with the requirements of section 10-16-705 (16) shall preclude a carrier from contracting with a provider.

Source: L. 97: Entire part added, p. 1332, § 2, effective July 1. **L. 2002:** (3) added, p. 1299, § 15, effective January 1, 2003.

10-16-708. Rule-making authority of commissioner. The commissioner may promulgate rules as necessary for carrying out the commissioner's duties under this part 7.

Source: L. 97: Entire part added, p. 1332, § 2, effective July 1.

10-16-709. Evaluation - nonparticipating health-care providers - legislative declaration - rules. (1) (a) The general assembly hereby finds and determines that not all health-care providers contract with all health insurers and therefore not all are participating providers. Health-care providers who do not contract with a carrier are considered to be nonparticipating providers as to that carrier. In addition, not all health-care providers are aware of the terms of health insurance coverage for health-care services provided to a consumer insured through individual or group health-care coverage. Therefore, the general assembly determines that there is a need to inform insured consumers of the scope of health insurance coverage available to the consumer for the services of nonparticipating providers who render services in a participating facility and the extent of an insured consumer's responsibility when services are rendered to an insured by a nonparticipating provider.

(b) The general assembly hereby declares that it is in the best interest of the residents of this state to provide administrative direction to health insurance carriers, health-care providers, and health facilities to provide timely notice to a consumer concerning when the person may or may not incur additional charges for covered health benefits received from health care providers.

(2) The insurance commissioner shall, in collaboration with the division of professions and occupations within the department of regulatory agencies, the department of public health and environment, any other state agency, and any interested party, hold public hearings to determine the extent and source of the problem of a consumer being billed for an amount not paid by his or her health insurance as a result of a nonparticipating provider delivering health-care services in a participating facility. These hearings shall also include an evaluation of the following:

(a) Payments to nonparticipating providers in participating facilities;

(b) Methods to improve disclosure to consumers of individual and group health insurance;

(c) When a person may be responsible for amounts in excess of the person's covered benefits from a nonparticipating provider;

(d) What the carrier's responsibilities are for payment for health benefits covered under the person's health benefit plan; and

(e) The appropriate appeals process for insurers and health-care providers to settle disputes.

(3) The insurance commissioner, the department of public health and environment, and the division of professions and occupations, including, but not limited to, any **type 1** board under the supervision of the division of professions and occupations, may promulgate rules in accordance with the findings from the evaluation conducted pursuant to subsection (2) of this section.

(4) On or before February 1, 2005, the insurance commissioner shall report the findings of the evaluation pursuant to subsection (2) of this section to the business affairs and labor committees of the house of representatives and the senate. The insurance commissioner shall include in the report a description of the rules promulgated pursuant to subsection (3) of this section. If a state agency did not promulgate rules pursuant to subsection (3) of this section, that state agency shall submit to the insurance commissioner, for inclusion in the commissioner's report to the business affairs and labor committees of the house of representatives and senate, the reasons why rules were not promulgated pursuant to subsection (3) of this section.

Source: L. 2004: Entire section added, p. 965, § 4, effective May 21.

10-16-710. Reporting to commissioner - medication-assisted treatment - rules. (1) A carrier shall report to the commissioner:

(a) The number of in-network providers who are federally licensed to prescribe medication-assisted treatment for substance use disorders, including buprenorphine; and

(b) The number of prescriptions filled by enrollees for medication-assisted treatment for substance use disorders; and

(c) The carrier's efforts to ensure sufficient capacity for and access to medication-assisted treatment for substance use disorders.

(2) The commissioner shall promulgate rules concerning the reporting requirements specified in subsection (1) of this section, including the reporting period, the frequency of reporting, and any other provisions necessary to comply with the reporting requirement.

Source: L. 2020: Entire section added, (SB 20-007), ch. 286, p. 1391, § 9, effective July 13.

PART 8

TASK FORCE TO EVALUATE HEALTH CARE NEEDS FOR COLORADO

10-16-801. (Repealed)

Source: L. 2003: Entire part repealed, p. 1785, § 17, effective July 1.

Editor's note: This part 8 was added in 2001 and was not amended prior to its repeal in 2003. For the text of this part 8 prior to 2003, consult the 2002 Colorado Revised Statutes.

PART 9

MULTIPLE EMPLOYER WELFARE ARRANGEMENT PILOT PROGRAM

10-16-901 to 10-16-910. (Repealed)

Editor's note: (1) This part 9 was added in 2003. For amendments to this part 9 prior to its repeal in 2008, consult the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

(2) Section 10-16-910 (1) provided for the repeal of this part 9, effective July 1, 2008. (See L. 2003, p. 1779.)

PART 10

HEALTH-CARE COVERAGE COOPERATIVES

Cross references: For provisions relating to health care coverage cooperatives prior to 2004, see article 18 of title 6 as contained in Colorado Revised Statutes 2003.

Law reviews: For article, "H.B. 94-1193: Health Care Purchasing Reform", see 23 Colo. Law. 2763 (1994).

10-16-1001. Legislative declaration. (1) The general assembly hereby recognizes that, through the sunset review for the division of insurance within the department of regulatory agencies in October 2001, the general assembly adopted a recommendation to consolidate and relocate the regulatory functions concerning health-care cooperatives. The provisions of parts 1, 2, and 4 of article 18 of title 6, C.R.S., were, therefore, repealed and relocated to this part 10.

(2) The general assembly hereby finds that:

(a) Under the current health-care system in this state, individuals risk losing their health-care coverage when they lose or change jobs or when coverage becomes unaffordable;

(b) Continued escalation of health-care costs threatens the continued economic vitality of the state; and

(c) Health care is a critical part of the economy of this state, representing a significant percentage of public and private spending, and affects all industries and individuals in this state.

(3) The general assembly hereby determines that:

(a) Comprehensive health-care benefits that meet the full range of health needs, as mandated by Colorado and federal law, should be readily available to citizens of this state;

(b) The current high quality of health care in this state should be maintained;

(c) Employers and their employees in this state should be afforded a meaningful opportunity to choose from a range of health plans, health-care providers, and treatments;

(d) Competition in the health-care industry should ensure that health plans and health-care providers are efficient and charge reasonable prices;

(e) All individuals should have a responsibility to pay their fair share of the costs of health-care coverage;

(f) Colorado's health-care system should build on the strength of the employment-based coverage arrangements that now exist in this state; and

(g) In order to help control health-care costs, consumers should be empowered to organize to directly negotiate health-care prices with providers.

(4) The general assembly, therefore, declares that the purposes of this part 10 are to:

(a) Promote control of the cost of health care for employers, employees, and individuals who pay for health-care coverage by pooling purchasing power among consumers and organizing providers so that health-care services are delivered in the most efficient manner;

(b) Allow health-care cooperatives established under this part 10 flexibility in the determination of plans and coverages they provide to members and the selection of health provider networks, plans, and providers with which they contract for services;

(c) Promote individual choice among health plans and health-care providers;

(d) Ensure high quality health care; and

(e) Encourage all individuals to take responsibility for their health-care coverage by pooling consumer purchasing power through the organization of health-care markets in a more efficient and effective manner.

(5) The general assembly hereby finds, determines, and declares that the rapidly changing health-care market provides unique opportunities for health-care providers to organize themselves into new forms of collaborative systems to deliver high quality health care at competitive market prices to cooperatives and other purchasers. This part 10 is enacted to encourage such collaborative arrangements and to promote market-based competition among health-care providers.

(6) The general assembly further recognizes that, in order to achieve the most effective use of resources and medical technology to respond to changing market conditions, providers who would otherwise be competitors with each other will need to horizontally integrate in order to develop collaborative arrangements to guarantee an adequate number of providers to service the market and to vertically integrate in order to guarantee that those who receive services will have a continuum of care as appropriate to their care needs.

(7) The general assembly also recognizes that to effect such new forms of collaborative systems and integration of providers to service the market will require an analysis of:

(a) Existing methods of providing services, contracting, collaborating, and networking among providers; and

(b) The extent and type of regulatory oversight of licensed provider networks or licensed individual providers that is appropriate to protect the public.

Source: L. 2004: Entire part added, p. 992, § 14, effective August 4. **L. 2019:** (2)(a), (3)(a), (3)(e), (3)(f), (4)(a), and (4)(e) amended and (3)(g) added, (SB 19-004), ch. 205, p. 2190, § 2, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1002. Definitions. As used in this part 10, unless the context otherwise requires:

(1) Repealed.

(2) "Cooperative" or "health-care coverage cooperative" means a health-care coverage cooperative created pursuant to this part 10 as an entity that provides to its members health coverage and health-care purchasing services, including but not limited to detailed information on comparative prices, usage, outcomes, quality, and member satisfaction with provider networks. "Cooperative" does not include a cooperative association organized without capital stock in accordance with article 55 of title 7, C.R.S., that is subject to articles 121 to 137 of title 7, C.R.S., and that had filed articles of incorporation with the secretary of state on or before March 15, 1991.

(3) "Health information" has the same meaning as "medical information", as set forth in section 18-4-412 (2)(b), C.R.S. "Health information" also includes information that relates to the past, present, or future physical or mental health of the member and its eligible employees and to payment for the provision of health care to the member and its eligible employees.

(4) "Licensed provider network" shall have the same meaning as in section 6-18-301.5 (1), C.R.S.

(5) "Managed care" has the same meaning as "managed care plan", as defined in section 10-16-102 (43).

(6) (a) "Member" means any public or private employer that has employees covered for health benefits through a cooperative.

(b) If, pursuant to section 10-16-1009 (3)(l), a cooperative provides coverage to individuals and allows individuals to join the cooperative, "member" may also include an individual who is covered by a plan purchased through a cooperative and any dependent of the individual, including a dependent child who is under twenty-six years of age.

(6.5) "Member class" means the class of member based on whether the member would qualify for coverage in the individual market, the small employer fully insured market, the large employer fully insured market, or the employer self-insured market.

(7) "Person with financial interest in the cooperative's business" means one of the following or an immediate family member of one of the following:

(a) A health-care provider who is contracting or attempting to contract, directly or indirectly, with the cooperative;

(b) An individual who is an employee or member of the board of directors of, has a substantial ownership interest in, or derives substantial income from an entity or person that is contracting or attempting to contract, directly or indirectly, with the cooperative; or

(c) An employee of an association, law firm, or other institution or organization that represents the interests of one or more entities or persons that are contracting or attempting to contract, directly or indirectly, with the cooperative.

(8) "Provider network" means a group of health-care providers formed to provide health-care services to individuals.

(9) "Purchaser" means an individual, an organization, or a governmental entity that makes health benefit purchasing decisions on behalf of a group of individuals.

(9.5) "Self-insured" means not insured under a plan underwritten by a carrier.

(10) "Utilization management" means programs designed to assure appropriate utilization of health services relative to established standards or norms.

(11) Repealed.

Source: L. 2004: Entire part added, p. 993, § 14, effective August 4. **L. 2013:** (5) amended, (HB 13-1266), ch. 217, p. 989, § 52, effective May 13. **L. 2019:** (1) and (11) repealed, (5) and (6)(b) amended, and (6.5) added, (SB 19-004), ch. 205, p. 2190, § 3, effective August 2. **L. 2025:** (9.5) added, (SB 25-275), ch. 377, p. 2038, § 46, effective August 6.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1003. Privacy of health information. (1) Individually identifiable health information collected for or by a cooperative is subject to HIPAA.

(2) (a) All disclosures of individually identifiable health information shall be restricted to the minimum amount of information necessary to accomplish the purpose for which the information is being disclosed.

(b) Any cooperative shall implement administrative, technical, and physical safeguards for the security of identifiable health information.

(3) (a) Subject to appropriate procedures established by a cooperative, an individual has the right to know whether any individual or entity uses or maintains individually identifiable health information concerning the individual and for what purpose the information may be used or maintained.

(b) Subject to appropriate procedures established by a cooperative, an individual has the right, with respect to identifiable health information concerning the individual that is recorded in any form or medium, to:

(I) See such information;

(II) Copy such information; and

(III) Have a notation made with or in such information including suggestions for amendments or corrections to such information requested by the individual or the individual's representative.

(4) Provider networks and providers in a network shall maintain the confidentiality of medical records as otherwise required by section 18-4-412, C.R.S., or other applicable law.

Source: L. 2004: Entire part added, p. 995, § 14, effective August 4. **L. 2019:** (1) amended, (SB 19-004), ch. 205, p. 2191, § 4, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1004. Health-care coverage cooperatives - establishment - fees. (1) (a) There is hereby authorized the creation of entities to be known as health-care coverage cooperatives. A health-care coverage cooperative may be created as any lawful entity under articles 55, 56, 58, 101 to 117, or 121 to 137 of title 7, C.R.S., so long as such entity operates for the mutual benefit of its members. Entities created pursuant to this part 10, in addition to the matters otherwise required, are subject to this part 10.

(b) Each cooperative shall follow the organizational requirements and corporate governance requirements of its statutory incorporation and, in addition, shall provide internal procedures that comply with section 10-16-1009.

(2) (a) (I) A cooperative organized on or after August 4, 2004, for the purposes of securing health-care coverage for its members and their eligible employees shall file articles of organization with the secretary of state and shall provide a copy of such articles to the commissioner in such form as the secretary and the commissioner may require consistent with this part 10 and title 7, C.R.S.

(II) For cooperatives formed prior to August 4, 2004, the executive director of the department of health care policy and financing shall provide the commissioner with such cooperatives' articles of organization.

(b) Any person or entity operating or holding itself out as a cooperative shall apply for and obtain a certificate of authority to operate as a cooperative pursuant to sections 10-16-1005 and 10-16-1006.

(c) No individual or entity that organizes a cooperative may become or attempt to become a person with financial interest in the cooperative's business for a period of three years after organization of the cooperative.

(3) (a) A cooperative is organized when the articles of organization are filed with the secretary of state or, if a delayed effective date is specified in the articles as filed with the secretary of state and a certificate of withdrawal is not filed, on such delayed effective date. The existence of the cooperative begins upon organization; except that no cooperative shall secure health-care coverage for its members until a certificate of authority has been issued by the commissioner pursuant to section 10-16-1005 (1).

(b) Except in a proceeding by the state to cancel or revoke the organization of, or involuntarily dissolve, the cooperative, the secretary of state's filing of the articles of organization shall be conclusive and irrefutable proof that all conditions precedent to organization have been met.

(4) Each cooperative shall file a report pursuant to section 7-136-107, C.R.S., and pay the required fee, which shall be determined and collected pursuant to section 24-21-104 (3), C.R.S., in lieu of all franchise or corporation license taxes.

(5) (a) Except as allowed by section 10-16-1014 or subsection (5)(b) of this section, the division of insurance shall not participate in the formation or administration of a health-care coverage cooperative created pursuant to this part 10.

(b) The commissioner may provide technical assistance in the formation of a cooperative created pursuant to this part 10 so long as the cooperative is not formed or administered by the commissioner as an entity or instrumentality of the state.

Source: L. 2004: Entire part added, p. 996, § 14, effective August 4. **L. 2011:** (1)(a) amended, (SB 11-191), ch. 197, p. 820, § 4, effective April 2, 2012. **L. 2019:** (5) amended, (SB 19-004), ch. 205, p. 2192, § 5, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1005. Issuance of certificate of authority by commissioner for cooperative to purchase health-care coverage. (1) (a) (I) (A) On and after August 4, 2004, an unlicensed cooperative conducting business pursuant to this part 10 shall file an application with the commissioner for issuance of a certificate of authority to purchase health-care coverage for members and their eligible employees. An application shall include the following information: The name of the cooperative and any agent for service of process; details concerning provisions to govern the business and affairs of the cooperative, including management and organizational structure; an affidavit signed under oath by an officer of the organization that the cooperative is in compliance with sections 10-16-1004 (2)(c) and 10-16-1008 (3); and the names of managing personnel of the cooperative. The commissioner shall grant a certificate of authority to an applicant under this section unless the application fails to comply with this part 10. The commissioner shall establish an application filing fee, not to exceed one thousand one hundred

dollars, to recover the direct costs of the commissioner in conducting the review required by this section. Each cooperative issued a certificate of authority pursuant to this section shall annually submit such information as the commissioner may reasonably require to determine that a cooperative continues to be in compliance with the provisions of this part 10. The commissioner shall establish a fee, not to exceed one thousand one hundred dollars annually, to recover the direct costs of the commissioner in determining annually that a cooperative is in compliance with the provisions of this part 10.

(B) Except as provided in section 10-16-1004 (3)(b), no cooperative shall take any action enumerated in section 10-16-1009 unless a certificate of authority has been issued pursuant to this section by the commissioner. Any person or entity applying to obtain a certificate of authority as required by section 10-16-1004 (2)(b) that fails to obtain a certificate of authority by December 1, 2004, shall cease to engage in any activity for which a certificate of authority is required pursuant to this part 10 until a certificate of authority is issued by the commissioner pursuant to this section and section 10-16-1006.

(C) Cooperatives that have been issued a certificate of authority by the executive director of the department of health care policy and financing prior to August 4, 2004, shall submit proof of such certificate of authority to the commissioner prior to November 1, 2004. The commissioner shall reissue a certificate of authority to the cooperative on or before December 1, 2004.

(II) A cooperative shall be required to post a fidelity or employee dishonesty bond or deposit with the commissioner a certificate of deposit or securities in a minimum amount equal to at least two months' premiums held by the cooperative or its administrator as of its annual renewal date in order to be granted a certificate of authority under this section. If a cooperative contracts with an outside administrator for all premium-handling functions, the cooperative itself will not be required to post a bond in order to comply with the provisions of this subparagraph (II) so long as the cooperative submits to the commissioner evidence that such administrator has obtained a bond in the required amount.

(b) The commissioner may grant a temporary certificate of authority to any cooperative. Any such temporary certificate of authority shall be valid for a period of one year after the date of issuance.

(c) Notwithstanding the provisions of part 2 of article 72 of title 24, C.R.S., an application, together with any supporting material and responses from the commissioner, shall not be considered a public record until the commissioner approves the application or until an organizer requests a hearing on the commissioner's denial of the application.

(2) The commissioner shall respond in writing to each application for a certificate of authority within thirty days after receipt by the commissioner. The commissioner shall either approve the application or shall inform the organizers of specific changes to the application that the commissioner deems necessary for approval under this part 10. Each applicant shall respond to the commissioner's comments within thirty days after receipt. The commissioner shall either approve the application within thirty days after receipt of such changes or request additional changes to the application. The time limits contained in this subsection (2) shall apply to all phases of the application process except hearings conducted pursuant to article 4 of title 24, C.R.S.

Source: L. 2004: Entire part added, p. 997, § 14, effective August 4.

10-16-1006. Authority to deny application for, revoke, or suspend certificate of authority. (1) On and after August 4, 2004, the commissioner may deny an application for a certificate of authority pursuant to section 10-16-1005 or revoke or suspend a certificate of authority of any cooperative found to be in violation of this part 10.

(2) (a) Any party may request a hearing pursuant to article 4 of title 24, C.R.S., on any action of the commissioner denying an application for a certificate of authority or revoking or suspending a certificate of authority.

(b) Any hearing conducted under this section shall be conducted pursuant to article 4 of title 24, C.R.S., and section 10-1-127, and the commissioner may use the services of an administrative law judge appointed pursuant to part 10 of article 30 of title 24, C.R.S.

(c) Any final decision of the commissioner under this part 10 shall be subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S.

Source: L. 2004: Entire part added, p. 999, § 14, effective August 4.

10-16-1007. Prohibition on cooperatives transacting insurance business. A cooperative shall not perform any activity included in the definition of transacting insurance business in this state, as provided in section 10-3-903, except as otherwise authorized in the powers, duties, and responsibilities of cooperatives as set forth in section 10-16-1009. A cooperative shall not establish or engage in the activities of a health maintenance organization.

Source: L. 2004: Entire part added, p. 999, § 14, effective August 4. **L. 2013:** Entire section amended, (HB 13-1266), ch. 217, p. 990, § 53, effective May 13.

10-16-1008. Administrative structure of cooperatives - board of directors - officers - employees. (1) (a) (I) The affairs of the cooperative shall be managed in accordance with the legal structure required of the entity and, except as provided in subsection (1)(a)(II) of this section, governed by persons elected by the members from their own number. The governing body of the cooperative shall adopt bylaws and rules for the cooperative.

(II) The members of the cooperative may elect to the governing body up to three individuals who are not able to join the cooperative as members, but at least eighty percent of the governing board must consist of members of the cooperative.

(b) Members of a cooperative shall be entitled to equal participation and benefit from the cooperative; except that a cooperative at its option may extend voting rights to eligible employees.

(c) The governing body of the cooperative shall meet at such times and places as it determines necessary to operate the cooperative in accordance with this part 10.

(2) A cooperative may provide fair remuneration for the time actually spent by its officers and directors in its service and for the service of the members of its executive committee.

(3) An individual who is a member of a governing body of a cooperative may not be a person with financial interest in the cooperative's business during his or her term on the governing body or during the twelve-month period immediately before or after service on such governing body.

(4) The bylaws may provide that no member of the governing body of a cooperative shall occupy any position in the cooperative except the chief executive officer and secretary on regular salary or substantially full-time pay. The bylaws may provide for an executive committee and may allot to the executive committee all the functions and powers of the board of directors, subject to general direction and control by the board.

(5) When a vacancy occurs on the governing body of a cooperative other than by expiration of a member's term, the remaining members of the governing body shall fill the vacancy by majority vote.

(6) The governing body of a cooperative may appoint a chief executive officer of the cooperative and other staff necessary to administer the cooperative. The chief executive officer and other staff serve at the pleasure of the governing body.

(7) No cooperative may assume any liability for payment for health-care services covered by a plan purchased through the cooperative.

Source: L. 2004: Entire part added, p. 999, § 14, effective August 4. **L. 2019:** (1) amended, (SB 19-004), ch. 205, p. 2192, § 6, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1009. Powers, duties, and responsibilities of cooperatives. (1) Each cooperative organized pursuant to this part 10 shall:

(a) Establish the conditions of cooperative membership;

(b) Provide to cooperative members and their eligible employees clear, standardized information about each provider network, licensed provider network, carrier, or other provider contracted with by the cooperative, including, but not limited to, information on price, benefits, costs, quality, patient satisfaction, membership, and responsibilities and obligations;

(c) Offer dependent coverage;

(d) Repealed.

(e) Obtain the necessary contact information and resources to provide to members and their eligible employees the information described in paragraph (b) of this subsection (1);

(f) Contract only for insurance functions listed in section 10-3-903, with entities authorized to do business in this state by the commissioner pursuant to this title that have:

(I) The capacity to administer the health benefit plan or services to be offered;

(II) The ability to monitor and evaluate the quality and cost-effectiveness of care and applicable procedures;

(III) The ability to report quality and outcomes information necessary for the cooperative to report quality information to members and their eligible employees; and

(IV) The ability to assure members and their eligible employees adequate access to health-care providers, including an adequate number and type of providers for the risk pool involved;

(g) Develop and implement a marketing plan that will widely publicize the cooperative to potential members and their eligible employees and develop and implement methods for informing the public about the cooperative and its services;

(h) State clearly all administrative and broker or agent fees associated with membership in all materials published for the purpose of soliciting members and their eligible employees or that may be used by potential members in deciding whether to join the cooperative;

(i) Establish administrative and accounting procedures for the operation of the cooperative and members' services, prepare an annual cooperative budget, and prepare annual program and fiscal reports on cooperative operations;

(j) Maintain all records, reports, and other information of the cooperative;

(k) Maintain a trust account or accounts for the deposit of premium moneys collected pursuant to subsection (3)(e) of this section, to be paid to carriers or licensed provider networks or licensed individual providers for coverage offered through the cooperative. A cooperative shall have a fiduciary duty with respect to premium moneys collected for carriers and licensed provider networks offered through the cooperative.

(l) Annually report on operations of the cooperative, including program and financial operations, and provide for internal and independent audits;

(m) Disclose to members and potential members whether or not the cooperative has been granted a temporary certificate of authority pursuant to section 10-16-1005 (1)(b);

(n) Offer the same premiums and any negotiated health-care prices to all member classes, if any, equally; except that a cooperative may offer different premiums or negotiated health-care prices to members who are not small employers;

(o) Consider all individuals in all individual health benefit plans offered through the cooperative, including those individuals who do not enroll in the plans through the exchange, to be members of a single risk pool;

(p) Consider all covered persons in small employer health benefit plans offered through the cooperative, including those covered persons who do not enroll in plans through the exchange, to be members of a single risk pool.

(2) A self-insured employer may join a cooperative in order to have access to the discounted provider rates that the cooperative may negotiate on behalf of its self-insured members.

(3) Each cooperative organized pursuant to this part 10 may:

(a) Repealed.

(b) Set reasonable fees for membership in the cooperative that will finance all reasonable and necessary costs incurred in administering the cooperative;

(c) and (d) Repealed.

(e) Subject to paragraph (l) of subsection (1) of this section, provide premium collection services for plans and licensed provider networks or licensed individual providers offered through the cooperative;

(f) Reject, or allow a carrier to reject, an employer from membership or drop, or allow a carrier to drop, an employer from membership if the employer or any of its employee members fails to pay premiums or engages in fraud or material misrepresentation in connection with a plan purchased through the cooperative. If an employee is dropped from membership due to the employer's failure to pay premiums or engagement in fraud or material misrepresentation, the cooperative may offer a special enrollment period in accordance with section 10-16-105.7 (3) to allow the employee to enroll in the individual member class, if available.

(g) Contract with qualified independent third parties for any service necessary to carry out the powers and duties authorized or required by this part 10;

(h) Contract with licensed insurance agents or brokers to market coverage made available through the cooperative to its members. A cooperative shall use a uniform fee schedule for all agents and brokers. Such fee schedule shall not vary based on the actual or expected health status or medical utilization of the group to which coverage is sold.

(i) Exclude any carrier, provider network, or provider or freeze enrollment in any carrier, provider network, or provider for failure to achieve established quality, access, or information reporting standards of the cooperative;

(j) Prohibit members who drop coverage through the cooperative from reenrolling for up to twelve months in coverage purchased through the cooperative;

(k) Repealed.

(l) Offer coverage for individuals who are members;

(m) Establish employer contribution requirements. Such requirements may differ by benefit plan, benefit package, or carrier.

(4) No cooperative organized pursuant to this part 10 may:

(a) Exclude from membership in the cooperative any prospective members, or dependents of prospective members, who agree to pay fees for membership and any premium for coverage through the cooperative and who abide by the bylaws and rules of the cooperative and satisfy the requirements of the benefit plan selected;

(b) Differentiate classes of membership on the basis of industry type, race, religion, gender, education, health status, or income;

(c) Commit any act constituting a rebate prohibited by section 10-3-1104 (1)(g). The commissioner shall enforce this paragraph (c) pursuant to part 11 of article 3 of this title.

(d) Prohibit any hospital, health maintenance organization, or other provider, as a condition of contracting to provide services through the cooperative, from providing services through a subcontract or subcontracts with any other hospital, health maintenance organization, or other provider meeting the cooperative's quality standards;

(e) Charge any fee not directly related to health care or the administration of health-care purchasing functions;

(f) As a condition of membership, require any member, eligible employee, or dependent to subscribe to non-health-care-related products or services;

(g) Knowingly operate the cooperative or market the cooperative in a county or primary metropolitan statistical area in a way that would cause the cooperative to select a risk pool with actuarially projected health-care utilization over a two-year period that is below the projected average for all individuals residing in that county or primary metropolitan statistical area. Such measurement and comparison of projected utilization by members of the cooperative to all individuals shall be done on a county or primary metropolitan statistical area basis and not across all members of the cooperative.

(h) Knowingly authorize or select any carrier, provider, licensed provider network, licensed individual provider, or individual provider that does not comply with or conform to the applicable requirements or standards of this title.

Source: L. 2004: Entire part added, p. 1000, § 14, effective August 4. **L. 2019:** (1)(d), (3)(a), (3)(c), (3)(d), and (3)(k) repealed, (1)(o) and (1)(p) added, and (2), (3)(f), (3)(l), and (4)(a) amended, (SB 19-004), ch. 205, p. 2192, § 7, effective August 2. **L. 2020:** (1)(k) amended, (HB

20-1402), ch. 216, p. 1044, § 17, effective June 30. **L. 2025:** (2) amended, (SB 25-275), ch. 377, p. 2039, § 47, effective August 6.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1010. Marketing requirements of cooperatives. (1) A cooperative shall use appropriate, efficient, and standardized means to notify members and prospective members and their eligible employees of the availability of sponsored health-care coverage from the cooperative.

(2) A cooperative shall make available to members and prospective members and their eligible employees marketing materials that accurately summarize the health benefit plans that are offered by its licensed provider networks, licensed individual providers, and other carriers, and rates, costs, and accreditation information relating to those plans. A cooperative shall also summarize the services offered by all other provider networks and individual providers the cooperative offers, the rates for those services, and accreditation information relating to those provider networks.

(3) A cooperative may offer nonlicensed provider networks or individual providers only to self-insured members of the cooperative. Nonlicensed provider networks or individual providers may also be offered to members not self-insured if the services offered do not involve transacting insurance business, as defined in section 10-3-903. The members may choose which health benefit plans shall be offered to eligible employees and may change the selection each year. The employee may be given options with regard to health benefit plans and the type of managed care system under which benefits will be provided.

Source: L. 2004: Entire part added, p. 1004, § 14, effective August 4.

10-16-1011. Requirements for waivered health care coverage cooperatives - rules. (Repealed)

Source: L. 2004: Entire part added, p. 1004, § 14, effective August 4. **L. 2013:** (5)(b)(II)(A) amended, (HB 13-1266), ch. 217, p. 990, § 54, effective May 13. **L. 2019:** Entire section repealed, (SB 19-004), ch. 205, p. 2194, § 8, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1012. Application of rating factors inside a waivered cooperative. (Repealed)

Source: L. 2004: Entire part added, p. 1007, § 14, effective August 4. **L. 2019:** Entire section repealed, (SB 19-004), ch. 205, p. 2196, § 9, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1013. Violations of article by persons involved with operations of cooperatives - enforcement - penalties. (1) As used in this section, unless the context otherwise requires, "responsible party" means a member of the governing body or an executive officer of a cooperative.

(2) (a) After notice and the opportunity for a hearing pursuant to article 4 of title 24, C.R.S., the commissioner may enforce the provisions of this part 10 by issuing orders directed to any responsible party, including but not limited to cease-and-desist orders, as are deemed necessary if the commissioner finds that:

(I) Such person has violated this part 10 or any lawful rule promulgated pursuant to this part 10, engaged in any unsafe or unsound practice in connection with a cooperative, engaged in an act, omission, or practice that constitutes a breach of fiduciary duty to a cooperative, or has been found liable for or guilty of a civil or criminal offense affecting such person's qualification to serve in such capacity; or

(II) (A) The cooperative has suffered or appears likely to suffer substantial financial loss or that the interests of its members and eligible employees could be seriously prejudiced by reason of such violation, practice, breach of fiduciary duty, or offense;

(B) Such person has received financial gain from such violation, practice, breach of fiduciary duty, or offense; or

(C) Such violation involves serious dishonesty or demonstrates a willful or continuing disregard for the safety or soundness of the cooperative.

(b) In addition to the actions authorized in paragraph (a) of this subsection (2), the commissioner may impose a civil penalty of up to twenty-five thousand dollars for each violation.

(c) In addition to the penalty provided in paragraph (b) of this subsection (2), if the commissioner determines that any person is in violation of the provisions of section 10-16-1004 (2)(c) or 10-16-1008 (3), the commissioner may order the responsible party suspended or removed from office.

(d) If the commissioner finds that extraordinary circumstances exist that require immediate action, such action may be taken immediately pursuant to section 24-4-105 (12), C.R.S., but a subsequent hearing shall promptly be afforded upon application to rescind the action taken.

(e) The commissioner may initiate informal actions to enforce this part 10 under this section. Such informal actions may include written agreements with, informal commitment letters from, or the forwarding of a letter of reprimand to, a cooperative or responsible party.

(3) Any person adversely affected by an order issued pursuant to this section may, within twenty days after the date of the order, request judicial review under section 24-4-106 (11). An action for judicial review shall not operate to stay or vacate a decision or order; except that the court may issue a stay pending review.

Source: L. 2004: Entire part added, p. 1007, § 14, effective August 4. **L. 2019:** (3) amended, (SB 19-004), ch. 205, p. 2196, § 10, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1014. Technical assistance to authorized cooperatives from division of insurance. (1) Subject to available appropriations, the commissioner may provide technical assistance to any cooperative that:

(a) to (c) Repealed.

(d) Establishes rules that specify that employer members shall take no action to limit their employees' choice of plans offered through the cooperative or to encourage or discourage employees from making particular choices of plans offered through the cooperative;

(e) Repealed.

(f) Develops and implements a marketing plan to publicize the cooperative to potential members and develops and implements methods for informing the public about the cooperative and its services;

(g) Develops specific plans to expand health-care coverage and to expand access to health care in this state; and

(h) Gives each covered member the opportunity to choose among carriers that contract with the cooperative.

(2) The technical assistance the commissioner may provide pursuant to subsection (1) of this section may include:

(a) Providing technical assistance in the formation of a cooperative pursuant to this part 10 so long as the cooperative is not formed or administered by the commissioner as an entity or instrumentality of the state;

(b) Educating communities, businesses, and nonprofit organizations about cooperatives; and

(c) Advertising or otherwise publicizing successful cooperatives that have been formed in the state.

Source: L. 2004: Entire part added, p. 1008, § 14, effective August 4. **L. 2019:** (1)(a), (1)(b), (1)(c), and (1)(e) repealed, (1)(h) amended, and (2) added, (SB 19-004), ch. 205, p. 2196, § 11, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1015. Health-care cooperatives - rule-making authority. The commissioner may promulgate rules consistent with this part 10 for purposes of carrying out the commissioner's duties under this part 10.

Source: L. 2004: Entire part added, p. 1009, § 14, effective August 4. **L. 2019:** Entire section amended, (SB 19-004), ch. 205, p. 2197, § 12, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

10-16-1016. State innovation waiver - authority to apply. As necessary to implement this part 10, the commissioner may apply to the secretary of the United States department of health and human services for a five-year state innovation waiver in accordance with section

1332 of the federal act, codified at 42 U.S.C. sec. 18052, and 45 CFR 155.1300. The commissioner shall ensure that a waiver application submitted pursuant to this section complies with the requirements specified in section 1332 of the federal act, codified at 42 U.S.C. sec. 18052, and 45 CFR 155.1308.

Source: L. 2019: Entire section added, (SB 19-004), ch. 205, p. 2197, § 13, effective August 2.

Cross references: For the legislative declaration in SB 19-004, see section 1 of chapter 205, Session Laws of Colorado 2019.

PART 11

COLORADO REINSURANCE PROGRAM

10-16-1101. Short title. The short title of this part 11 is the "Colorado Reinsurance Program Act".

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2176, § 1, effective May 17.

10-16-1102. Legislative declaration. (1) The general assembly hereby finds and declares that:

(a) All Coloradans deserve access to high-quality, affordable health care to help support their well-being and economic security;

(b) Increasing costs of health care in Colorado have led to premium increases for health insurance in the individual market that have created a financial burden for some Coloradans purchasing insurance in the individual market;

(c) That burden is heightened in rural areas of the state, where premiums are considerably higher than in metropolitan areas of the state and there is a lack of competition among health-care providers and carriers;

(d) Because of the financial burden high-cost health insurance places on consumers in rural areas, a considerable number of these cost-burdened consumers may not purchase health insurance, exacerbating the problems of few carriers, few plan options, and high health insurance costs in rural regions, as well as increasing the number of uninsured Coloradans; and

(e) Colorado has historically been a national leader in health-care innovation, and it is important to use that innovative spirit to address the rising costs of health care in the state by directing the commissioner of insurance to create a reinsurance program that will:

(I) Make private health insurance in the individual market more accessible and affordable;

(II) Encourage participation and competition by carriers throughout the state, but particularly in rural areas of the state, in order to give consumers the ability to seek value in health insurance coverage;

(III) Decrease costs of care, leading to lower premiums and restraining, if not decreasing, the growth in federal spending commitments in the individual market; and

(IV) Support and empower, and increase access to affordable, high-value health insurance for, consumers who are ineligible for premium tax credit subsidies while minimizing any potential negative effects on access to affordable, high-value insurance for consumers who are eligible for premium tax credit subsidies and cost-sharing reductions.

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2176, § 1, effective May 17.

10-16-1103. Definitions. As used in this part 11, unless the context otherwise requires:

(1) "Attachment point" means the amount set by the commissioner pursuant to section 10-16-1105 (2) for claims costs incurred by an eligible carrier for a covered person's covered benefits in a benefit year, above which the claims costs for benefits are eligible for reinsurance payments under the reinsurance program.

(2) "Benefit year" means the calendar year for which an eligible carrier provides coverage through an individual health benefit plan.

(3) "Coinsurance rate" means the rate set by the commissioner pursuant to section 10-16-1105 (2) at which the reinsurance program will reimburse an eligible carrier for claims incurred for a covered person's covered benefits in a benefit year, which claims exceed the attachment point but are below the reinsurance cap.

(4) "Commissioner" means the commissioner of insurance, the commissioner's deputies, or the division of insurance, as appropriate.

(5) "Eligible carrier" means a carrier that:

(a) Offers individual health benefit plans that comply with the federal act; and

(b) Incurs claims costs for a covered person's covered benefits in the applicable benefit year.

(6) "Hospital" means a hospital licensed or certified by the department of public health and environment pursuant to section 25-1.5-103 (1)(a).

(7) "Medicaid" means federal insurance or assistance as provided by Title XIX of the federal "Social Security Act", as amended, and the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5.

(8) "Medicare" means federal insurance or assistance provided by the "Health Insurance for the Aged Act", Title XVIII of the federal "Social Security Act", as amended, 42 U.S.C. sec. 1395 et seq.

(9) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the reinsurance program.

(10) "Reinsurance cap" means the amount set by the commissioner pursuant to section 10-16-1105 (2) for claims costs incurred by an eligible carrier for a covered person's covered benefits, above which amount the claims costs for benefits are no longer eligible for reinsurance payments.

(11) "Reinsurance payment" means an amount paid to an eligible carrier under the reinsurance program.

(12) "Reinsurance program" or "program" means the Colorado reinsurance program established under section 10-16-1105.

(13) "State innovation waiver" means a waiver of one or more requirements of the federal act authorized by section 1332 of the federal act, codified in 42 U.S.C. sec. 18052, and applicable federal regulations.

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2177, § 1, effective May 17.

10-16-1104. Commissioner powers and duties - rules - study and report. (1) The commissioner has all powers necessary to implement this part 11 and is specifically authorized to:

(a) Enter into contracts as necessary or proper to carry out the provisions and purposes of this part 11, including contracts for the administration of the reinsurance program and with appropriate administrative staff, consultants, and legal counsel;

(b) Take legal action as necessary to avoid the payment of improper claims under the reinsurance program;

(c) Establish administrative and accounting procedures for the operation of the reinsurance program;

(d) Establish procedures and standards for carriers to submit claims under the reinsurance program;

(e) Establish or adjust the payment parameters in accordance with section 10-16-1105 (2) for each benefit year;

(f) Repealed.

(g) In accordance with section 10-16-1109, apply for a state innovation waiver or an extension of a state innovation waiver; apply for federal funds; or apply for both a waiver or extension of a waiver and federal funds for the implementation and operation of the reinsurance program;

(h) Apply for, accept, administer, and expend gifts, grants, and donations and any federal or state funds that may become available for the reinsurance program; and

(i) Adopt rules as necessary to implement, administer, and enforce this part 11, including rules necessary to align state law with any federal program and rules. The rules shall be adopted in accordance with the "State Administrative Procedure Act", article 4 of title 24, including the requirement to establish a representative group of participants pursuant to section 24-4-103 (2).

(2) (a) If the reinsurance program is approved pursuant to section 10-16-1109, the commissioner, during implementation of the program, shall evaluate the effect of the program on access to affordable, high-value health insurance for consumers who are eligible for premium tax credit subsidies and cost-sharing reductions and minimize any potential negative effects on those consumers.

(b) After the second full year of operation of the program, the commissioner shall complete a study that evaluates:

(I) The effects of the program on access to affordable, high-value health insurance for consumers who are eligible for premium tax credit subsidies and cost-sharing reductions; and

(II) Health plan affordability, including cost sharing and premiums.

(c) The commissioner shall issue a report on the study within one hundred twenty days after the end of the second full year of operation of the program, post the report on the division's website, and submit the report to the governor, the senate committee on health and human

services or its successor committee, and the house of representatives health and insurance committee or its successor committee.

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2178, § 1, effective May 17. **L. 2020:** (1)(f) repealed and (1)(g) amended, (SB 20-215), ch. 201, p. 998, § 3, effective June 30.

10-16-1105. Reinsurance program - creation - enterprise status - subject to waiver or funding approval - operation - payment parameters - calculation of reinsurance payments - eligible carrier requests - definition. (1) (a) There is hereby created in the division the Colorado reinsurance program to provide reinsurance payments to eligible carriers. Implementation and operation of the reinsurance program is contingent upon approval of a state innovation waiver, an extension of a state innovation waiver, or a federal funding request submitted by the commissioner in accordance with section 10-16-1109.

(b) (I) The reinsurance program is part of the Colorado health insurance affordability enterprise established pursuant to part 12 of this article 16.

(II) (Deleted by amendment, L. 2020.)

(c) If a state innovation waiver, an extension of a state innovation waiver, or a federal funding request submitted by the commissioner pursuant to section 10-16-1109 is approved, the commissioner shall implement and operate the reinsurance program in accordance with this section.

(d) The commissioner shall collect or access data from each eligible carrier as necessary to determine reinsurance payments, according to the data requirements under subsection (3)(c) of this section.

(e) (I) On a quarterly basis during the applicable benefit year, each eligible carrier shall report to the commissioner its claims costs that exceed the attachment point for that benefit year.

(II) For each applicable benefit year, the commissioner shall notify eligible carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year. By August 15 of the year following the applicable benefit year, the commissioner shall disburse all applicable reinsurance payments to an eligible carrier.

(2) (a) For purposes of determining eligibility for and calculating reinsurance payments under the reinsurance program for the 2020 benefit year in order to make private health insurance coverage more accessible and affordable and encourage increased carrier participation in rural parts of the state, the commissioner shall set the payment parameters at amounts to achieve:

(I) A reduction in claims costs of between thirty and thirty-five percent in geographic rating area numbers five and nine;

(II) A reduction in claims costs of between twenty and twenty-five percent in geographic rating area numbers four, six, seven, and eight; and

(III) A reduction in claims costs of between fifteen and twenty percent in geographic rating area numbers one, two, and three.

(a.5) To the greatest extent possible, the commissioner shall set the payment parameters for the 2021 benefit year at amounts to maintain the targeted claims reductions achieved in the 2020 benefit year.

(b) For the 2022 benefit year and each benefit year thereafter, after a stakeholder process, the commissioner shall establish and publish the payment parameters for that benefit year by March 15 of the immediately preceding calendar year. In setting the payment parameters under this subsection (2)(b), the commissioner shall consider the following factors as they apply in each geographic rating area in the state:

(I) Participation and competition by carriers in the individual market;

(II) Enrollment across all income levels and morbidity in the individual market;

(III) Participation and competition by providers; and

(IV) Rates in the individual market.

(c) If the amount of money from funding sources specified in section 10-16-1107 is anticipated to be inadequate to fully fund the payment parameters, the commissioner shall establish new payment parameters within the available money. The commissioner shall allow an eligible carrier to revise an applicable rate filing for the next benefit year based on the final payment parameters established pursuant to this subsection (2)(c) and on actual reinsurance payments received by the eligible carrier.

(3) (a) An eligible carrier that meets the requirements of this subsection (3) and subsection (4) of this section may request reinsurance payments from the reinsurance program.

(b) An eligible carrier must make requests for reinsurance payments in accordance with the requirements established by the commissioner.

(c) To receive reinsurance payments through the reinsurance program, an eligible carrier must, by April 30 of the year following the benefit year for which reinsurance payments are requested:

(I) Provide the commissioner with access to the data within the dedicated data environment established by the eligible carrier under the federal risk adjustment program under 42 U.S.C. sec. 18063; and

(II) Submit to the commissioner an attestation that the carrier has complied with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) An eligible carrier shall maintain records sufficient to substantiate the requests for reinsurance payments made pursuant to this section for at least six years. An eligible carrier shall also make those records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

(e) The commissioner may have an eligible carrier audited to assess the carrier's compliance with this section. The eligible carrier shall ensure that its contractors, subcontractors, and agents cooperate with any audit under this section.

(4) (a) (I) The commissioner shall calculate each reinsurance payment based on an eligible carrier's incurred claims costs for a covered person's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point for the applicable benefit year, the carrier is not eligible for a reinsurance payment.

(II) If the claims costs exceed the attachment point for the applicable benefit year, the commissioner shall calculate the reinsurance payment as the product of the coinsurance rate and the eligible carrier's claims costs, up to the reinsurance cap.

(b) A carrier is ineligible for reinsurance payments for claims costs for a covered person's covered benefits in the applicable benefit year that exceed the reinsurance cap.

(c) The commissioner shall ensure that reinsurance payments made to an eligible carrier do not exceed the total amount paid by the eligible carrier for any eligible claim. "Total amount paid by the eligible carrier for any eligible claim" means the amount paid by the eligible carrier based on the allowed amount less any deductible, coinsurance, or copayment, as of the time the data are submitted or made accessible under subsection (3)(c) of this section.

(d) An eligible carrier may request that the commissioner reconsider a decision on the carrier's request for reinsurance payments within thirty days after notice of the commissioner's decision. A final action or order of the commissioner under this subsection (4)(d) is subject to judicial review in accordance with section 24-4-106.

(5) In order to promote more cost-effective health-care coverage and to be fair to federal taxpayers by restraining growth in federal spending commitments, the commissioner shall require each eligible carrier that participates in the program to file with the commissioner, by a date and in a form and manner specified by the commissioner by rule, the care management protocols the eligible carrier will use to manage claims within the payment parameters.

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2180, § 1, effective May 17. **L. 2020:** (1)(a), (1)(b), (1)(c), (1)(e)(I), and IP(2)(b) amended and (2)(a.5) added, (SB 20-215), ch. 201, p. 998, § 4, effective June 30.

10-16-1106. Accounting - reports - audits. (1) The commissioner shall maintain an accounting for each benefit year of all:

(a) Money expended for reinsurance payments and administrative and operational expenses;

(b) Requests for reinsurance payments received from eligible carriers;

(c) Reinsurance payments made to eligible carriers; and

(d) Administrative and operational expenses incurred for the reinsurance program.

(2) By November 1 of the year following the applicable benefit year or sixty calendar days after the final disbursement of reinsurance payments for the applicable benefit year, whichever is later, the commissioner shall make available to the public a report summarizing the reinsurance program's operations for each benefit year. The commissioner shall post the report on the division's website.

(3) The reinsurance program is subject to audit by the state auditor. The commissioner shall ensure that all of the reinsurance program's contractors, subcontractors, and agents cooperate with the audit.

(4) On or before November 1, 2020, and on or before November 1 of each year thereafter, the division shall include an update regarding the program in its report to the members of the applicable committees of reference in the senate and house of representatives as required by the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2.

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2183, § 1, effective May 17. **L. 2020:** (4) amended, (SB 20-215), ch. 201, p. 999, § 5, effective June 30.

10-16-1107. Funding for reinsurance program - sources - permitted uses - reinsurance program cash fund - calculation of total funding for program. (1) (a) There is

hereby created in the state treasury the reinsurance program cash fund referred to in this section as the "fund", which consists of:

(I) Federal pass-through funding granted pursuant to 42 U.S.C. sec. 18052 (a)(3) or any other federal funds that are made available for the reinsurance program;

(II) Any money the general assembly appropriates to the fund for the program; and

(III) Any amounts allocated to the fund pursuant to section 10-16-1205 (2).

(b) All money deposited or paid into or transferred, allocated, or appropriated to the reinsurance program cash fund, including interest or income earned on the investment of money in the fund, is continuously available and appropriated to the division to be expended in accordance with this part 11. Any interest or income earned on the investment of money in the fund shall be credited to the fund.

(c) The reinsurance program cash fund is part of the Colorado health insurance affordability enterprise established pursuant to part 12 of this article 16.

(2) The commissioner may seek, accept, and expend gifts, grants, or donations from private or public sources for the operation, reserves, and sustainability of the reinsurance program.

(3) The commissioner may expend money received from the sources specified in subsections (1) and (2) of this section for:

(a) Reinsurance payments under the reinsurance program; and

(b) Administrative and operating expenses of the reinsurance program, the commissioner, and the division under this part 11.

(4) (a) If, after June 30, 2020, the United States congress enacts and the president signs federal legislation establishing or the secretary of the United States department of health and human services implements a federal reinsurance program that provides federal funding for the reinsurance program or otherwise makes additional federal funds available for the reinsurance program in excess of the amount received as federal pass-through funding pursuant to subsection (1)(a)(I) of this section, the commissioner shall notify the health insurance affordability board created in section 10-16-1207 of the amount of federal funding in excess of the federal pass-through funding that will be available for the reinsurance program and the date the funding is expected to be received.

(b) If the reinsurance program receives federal funding as described in this subsection (4) to make reinsurance payments to carriers in a given year after the health insurance affordability enterprise has allocated money to the reinsurance program pursuant to section 10-16-1205 (2) for that year, the commissioner shall return to the enterprise the allocation or a portion of the allocation, as determined by the enterprise, based on the amount of federal funding received for that year.

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2183, § 1, effective May 17. **L. 2020:** (1) amended and (4) added, (SB 20-215), ch. 201, p. 999, § 6, effective June 30.

Editor's note: House Bill 19-1245, referenced in subsection (1)(a)(III), became law and took effect August 2, 2019.

10-16-1108. Special assessments against hospitals and carriers - rules - enforcement. (Repealed)

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2184, § 1, effective May 17. **L. 2020:** Entire section repealed, (SB 20-215), ch. 201, p. 1001, § 7, effective June 30.

10-16-1109. State innovation waiver - federal funding - Colorado reinsurance program. (1) (a) For purposes of implementing and operating the reinsurance program as set forth in this part 11 for plan years starting on or after January 1, 2021, the commissioner may apply to the secretary of the United States department of health and human services for:

(I) In accordance with section 1332 of the federal act, codified at 42 U.S.C. sec. 18052, and 45 CFR 155.1300:

(A) One or more extensions of the initial two-year state innovation waiver received before June 30, 2020, of up to five years per extension; or

(B) A new state innovation waiver of up to five years to follow the initial two-year state innovation waiver approved before June 30, 2020, and subsequent extensions of any new state innovation waiver approved by the secretary;

(II) Federal funds for the reinsurance program; or

(III) A new or extended state innovation waiver and federal funds.

(b) An application for a state innovation waiver or for federal funds must clearly state that operation of the reinsurance program is contingent on approval of the waiver or funding request.

(c) The commissioner shall ensure that a waiver application submitted pursuant to this section complies with the requirements specified in section 1332 of the federal act, codified at 42 U.S.C. sec. 18052, and 45 CFR 155.1308.

(d) The commissioner shall include in a waiver application a request for a pass-through of federal funding in accordance with section 1332 (a)(3) of the federal act, 42 U.S.C. sec. 18052 (a)(3), to allow the state to obtain and use, for purposes of helping fund the reinsurance program, any federal funds that would, absent the waiver, be used to pay advance payment tax credits and cost-sharing reductions authorized under the federal act.

(2) The commissioner shall notify the following in writing of any federal actions regarding the waiver or funding request:

(a) The joint budget committee of the general assembly;

(b) The senate committee on health and human services or any successor committee; and

(c) The house of representatives committees on health and insurance and public health care and human services or any successor committees.

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2186, § 1, effective May 17. **L. 2020:** (1)(a) amended, (SB 20-215), ch. 201, p. 1001, § 8, effective June 30.

10-16-1110. Repeal of part - notice to revisor of statutes. (Repealed)

Source: L. 2019: Entire part added, (HB 19-1168), ch. 204, p. 2187, § 1, effective May 17. **L. 2020:** (2) repealed, (SB 20-215), ch. 201, p. 1001, § 9, effective June 30.

Editor's note: Section 1 of chapter 204, Session Laws of Colorado 2019, provided for the repeal of subsection (1) when the commissioner of insurance received notice from the United States department of health and human services of approval of the waiver or funding requested

under § 10-16-1109. The commissioner received notice on August 30, 2023, that pass-through funding was received and notified the revisor of statutes. On October 23, 2023, the revisor of statutes received the notice.

PART 12

HEALTH INSURANCE AFFORDABILITY ACT

10-16-1201. Short title. The short title of this part 12 is the "Health Insurance Affordability Act".

Source: L. 2020: Entire part added, (SB 20-215), ch. 201, p. 986, § 1, effective June 30.

10-16-1202. Legislative declaration. (1) The general assembly finds and declares that:

(a) The state, carriers, and hospitals share a common commitment to ensuring all Coloradans have access to affordable health care coverage because access to coverage improves health outcomes and provides financial security for Coloradans;

(b) Hospitals within the state incur the costs of uncompensated care to uninsured and underinsured populations;

(c) The economic downturn due to COVID-19 and its impacts on group and individual health care coverage in the state creates economic challenges for carriers from the potential lost revenue if people drop insurance coverage;

(d) This part 12 is enacted to provide the following services and benefits to carriers:

(I) Reducing the number of Coloradans who lack health care coverage by helping Coloradans to maintain consistent coverage;

(II) Providing stability in the insurance market;

(III) Reducing the movement of individuals between insured and uninsured status;

(IV) Offsetting the costs carriers would otherwise pay for covered persons' high medical costs so that premiums are set at more affordable levels; and

(V) Creating a healthier risk pool for all carriers by establishing a path for consistent coverage for individuals; and

(e) This part 12 is enacted to provide the following services and benefits to hospitals:

(I) Reducing the amount of uncompensated care provided by hospitals;

(II) Reducing the need of providers to shift costs of providing uncompensated care to other payers; and

(III) Expanding access to high-quality, affordable health care for low-income and uninsured Coloradans.

(2) The general assembly further finds and declares that, consistent with the determination of the Colorado supreme court in *Nicholl v. E-470 Public Highway Authority*, 896 P.2d 859 (Colo. 1995), the power to impose taxes is inconsistent with enterprise status under section 20 of article X of the state constitution, and the health insurance affordability fees and special assessments charged and collected by the health insurance affordability enterprise are fees, not taxes, because the fees and assessments are imposed for the specific purpose of allowing the enterprise to defray the costs of providing the business services specified in section 10-16-1204 (1)(a) to the carriers and hospitals that pay the fees and assessments and are

collected at rates that are reasonably calculated based on the benefits received by those carriers and hospitals.

Source: L. 2020: Entire part added, (SB 20-215), ch. 201, p. 986, § 1, effective June 30.

10-16-1203. Definitions. As used in this part 12, unless the context otherwise requires:

(1) "Board" means the health insurance affordability board created in section 10-16-1207.

(2) "Children's basic health plan" has the meaning set forth in section 25.5-8-103 (2).

(2.5) "Enhanced premium tax credit" means the premium tax credit, as amended by the federal "American Rescue Plan Act of 2021", Pub.L. 117-2, and the federal "Inflation Reduction Act of 2022", Pub.L. 117-169, 136 Stat. 1818 (2022), which expanded eligibility for and the amount of the premium tax credit.

(3) "Enterprise" means the Colorado health insurance affordability enterprise created in section 10-16-1204.

(4) "Federal poverty line" has the same meaning as "poverty line", as defined in 42 U.S.C. sec. 9902 (2).

(5) "Fee" means the health insurance affordability fee established and assessed pursuant to section 10-16-1205.

(6) "Fund" means the health insurance affordability cash fund created in section 10-16-1206.

(7) "Household income" has the same meaning as set forth in 26 U.S.C. sec. 36B (d)(2) of the federal "Internal Revenue Code of 1986", as amended.

(8) "Medicaid" means federal insurance or assistance as provided by Title XIX of the federal "Social Security Act", as amended, and the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5.

(9) "Medicare" means federal insurance or assistance provided by the "Health Insurance for the Aged Act", Title XVIII of the federal "Social Security Act", as amended, 42 U.S.C. sec. 1395 et seq.

(10) "Premium tax credit" means the refundable tax credit available pursuant to the federal act to assist certain individuals in purchasing a health benefit plan on the exchange.

(11) "Public benefit corporation" means a public benefit corporation formed pursuant to part 5 of article 101 of title 7 that is organized and operated by the exchange pursuant to section 10-22-106 (3) for the purpose of administering and operating a subsidy to reduce the costs of health care coverage offered under a state-subsidized individual health coverage plan.

(12) "Qualified individual" means an individual, regardless of immigration status, who:

(a) Is a Colorado resident;

(b) Has a household income of not more than three hundred percent of the federal poverty line; and

(c) Is not eligible for the premium tax credit, medicaid, medicare, or the children's basic health plan, except for individuals eligible pursuant to section 25.5-5-201 (6) or section 25.5-8-109 (7).

(13) "Reinsurance program" means the Colorado reinsurance program created in part 11 of this article 16.

(14) "Reinsurance program cash fund" means the reinsurance program cash fund created in section 10-16-1107.

(15) "State-subsidized individual health coverage plan" means a subsidized individual health coverage plan offered by carriers to qualified individuals through the public benefit corporation.

Source: L. 2020: Entire part added, (SB 20-215), ch. 201, p. 987, § 1, effective June 30. **L. 2025:** (12)(c) amended, (HB 25-1213), ch. 276, p. 1434, § 1, effective August 6. **L. 2025, 1st Ex. Sess.:** (2.5) added, (HB 25B-1006), ch. 10, p. 41, § 1, effective August 28.

10-16-1204. Health insurance affordability enterprise - creation - powers and duties - assess and allocate health insurance affordability fee and special assessment. (1) (a) There is hereby created in the division the Colorado health insurance affordability enterprise. The enterprise is and operates as a government-owned business within the division for the purpose of assessing and collecting the health insurance affordability fee from carriers that offer health benefit plans in the state and a special assessment on hospitals in the state and using and allocating the fee and assessment for the purposes specified in this part 12 in order to:

(I) Provide the following business services to carriers that pay the fee:

(A) Outreach and related work to increase enrollment in health benefit plans offered by carriers across the state;

(B) Increasing the number of individuals who purchase health benefit plans in the individual market by providing financial support to individuals to purchase private health insurance coverage;

(C) Funding the reinsurance program that offsets the costs carriers would otherwise pay for covering consumers with high medical costs;

(D) Improving the stability of the market throughout the state by providing consistent private health care coverage and reducing the movement of individuals from insured to uninsured status;

(E) Reducing provider cost shifting from the individual market and the uninsured to the group market; and

(F) Creating a healthier risk pool for all carriers by establishing a path for consistent coverage for individuals; and

(II) Provide the following business services to hospitals:

(A) Reducing the amount of uncompensated care provided by hospitals;

(B) Reducing the need of providers to shift costs of providing uncompensated care to other payers; and

(C) Expanding access to high-quality, affordable health care for low-income and uninsured Coloradans.

(b) (I) The enterprise constitutes an enterprise for purposes of section 20 of article X of the state constitution so long as it retains the authority to issue revenue bonds and receives less than ten percent of its total revenues in grants, as defined in section 24-77-102 (7), from all Colorado state and local governments combined. So long as it constitutes an enterprise pursuant to this section, the enterprise is not a district for purposes of section 20 of article X of the state constitution.

(II) The enterprise is hereby authorized to issue revenue bonds for the expenses of the enterprise, secured by revenues of the enterprise.

(2) The enterprise's primary powers and duties are:

(a) To assess and collect the fee specified in section 10-16-1205 (1)(a)(I);

(b) To assess and collect the special assessment on hospitals specified in section 10-16-1205 (1)(a)(II);

(c) To allocate money in the fund in accordance with section 10-16-1205 (2);

(d) To issue revenue bonds payable from the revenues of the enterprise;

(e) (I) To engage the services of third parties serving as contractors and consultants, including the division, for professional and technical assistance and advice and to supply other services related to the conduct of the affairs of the enterprise, without regard to the "Procurement Code", articles 101 to 112 of title 24. The enterprise shall encourage diversity in applications for contracts and shall generally avoid using single-source bids.

(II) The division shall provide office space and administrative staff to the enterprise pursuant to a contract entered into under this subsection (2)(e).

(f) To engage in outreach and related efforts to increase enrollment in health benefit plans across the state; and

(g) To adopt and amend or repeal policies for the regulation of its affairs and the conduct of its business consistent with this part 12.

(3) The enterprise shall exercise its powers and perform its duties as if the same were transferred to the division by a **type 2** transfer, as defined in section 24-1-105.

Source: L. 2020: Entire part added, (SB 20-215), ch. 201, p. 989, § 1, effective June 30.

10-16-1205. Health insurance affordability fees - special assessment on hospitals - allocation of revenues. (1) (a) (I) Starting in the 2021 calendar year, the enterprise shall assess and collect from carriers, by July 15 each year, a health insurance affordability fee. The fee amount is based on the following percentages of premiums collected by the following carriers in the immediately preceding calendar year on health benefit plans issued in the state:

(A) One and fifteen hundredths percent of premiums collected by nonprofit carriers; and

(B) Two and one-tenth percent of premiums collected by for-profit carriers.

(II) For the 2022 and 2023 calendar years, the enterprise shall assess and collect from hospitals a special assessment of twenty million dollars per year, subject to subsection (5) of this section. The enterprise shall not collect the special assessment for the 2022 calendar year before October 1, 2022.

(b) The enterprise shall use the fee, the special assessment on hospitals, and any other money available in the fund as follows, allocated in accordance with subsection (2) of this section:

(I) To provide funding for the reinsurance program;

(II) To provide payments to carriers to increase the affordability of health insurance on the individual market for Coloradans who receive the premium tax credit;

(III) To provide subsidies for state-subsidized individual health coverage plans purchased by qualified individuals;

(IV) To pay the actual administrative costs of the enterprise for implementing and administering this part 12, limited to three percent of the enterprise's revenues. Actual administrative costs include the following:

(A) The administrative costs of the enterprise, including the costs to implement and administer the programs established pursuant to this part 12;

(B) The enterprise's actual costs related to implementing and maintaining the fee and special assessment on hospitals, including personal services and operating expenses; and

(C) The costs for conducting analyses necessary to determine the payments to be made to carriers for the purposes described in subsection (1)(b)(II) of this section and the requirements for state-subsidized individual health coverage plans offered by carriers; and

(V) To pay the costs for consumer enrollment, outreach, and education activities regarding health care coverage, including:

(A) Increasing grants to the exchange's certified assistance network;

(B) Marketing for the exchange;

(C) Grants to community-based organizations that are able to assist with outreach and enrollment, particularly in communities that face the greatest barriers to enrolling in health care coverage; and

(D) Improving the connection between unemployment services and enrollment in health care coverage.

(c) This subsection (1) does not apply to plans or benefits provided under medicaid, medicare, or the children's basic health plan.

(2) (a) The enterprise shall transmit the fees and special assessments collected pursuant to this section to the state treasurer for deposit in the health insurance affordability cash fund created in section 10-16-1206 and, except as provided in subsection (4) of this section, shall allocate the money in the fund in accordance with this subsection (2).

(b) The enterprise shall allocate the revenues collected in 2021, and any other money deposited in the fund in 2021, as follows:

(I) Up to three percent for actual administrative costs as set forth in subsection (1)(b)(IV) of this section;

(II) To the reinsurance program cash fund, an amount necessary to fund the payment parameters of the reinsurance program, as determined pursuant to section 10-16-1105 (2), not to exceed ninety million dollars or, if the revenues collected pursuant to subsection (1)(a) of this section are less than ninety million dollars, the amount collected; and

(III) Of any remaining balance in the fund after deducting the allocations specified in subsections (2)(b)(I) and (2)(b)(II) of this section:

(A) Up to one percent of the total amount of revenues collected or deposited into the fund in 2021, but not more than one million five hundred thousand dollars, for implementation costs and consumer enrollment, outreach, and education activities regarding health care coverage as described in subsection (1)(b)(V) of this section; and

(B) The remaining balance to carriers to reduce the costs of individual health plans for individuals who purchase an individual health benefit plan on the exchange and receive the premium tax credit.

(c) The enterprise shall allocate the revenues collected in 2022, and any other money deposited in the fund in 2022, as follows:

(I) Up to three percent for actual administrative costs as set forth in subsection (1)(b)(IV) of this section;

(II) To the reinsurance program cash fund, eighty-eight million dollars; and

(III) Of the remaining balance in the fund after deducting the allocations specified in subsections (2)(c)(I) and (2)(c)(II) of this section:

(A) Thirty percent to carriers to reduce the costs of individual health plans for individuals who purchase an individual health benefit plan on the exchange and receive the premium tax credit; and

(B) Seventy percent for subsidies for state-subsidized individual health coverage plans purchased by qualified individuals.

(d) (I) Except as provided in subsections (2)(d)(IV) and (2)(e) of this section, the enterprise shall allocate the revenues collected in 2023 and each year thereafter, and any other money deposited in the fund in 2023 and each year thereafter, in the following amounts and order of priority:

(A) First, up to three percent for actual administrative costs as set forth in subsection (1)(b)(IV) of this section;

(B) Second, eighteen million dollars for subsidies for state-subsidized individual health coverage plans purchased by qualified individuals;

(C) Third, the amount remaining in the fund, up to seventy-three percent of the total amount of revenues collected or deposited into the fund in the applicable year, but not to exceed ninety million dollars, to the reinsurance program cash fund; and

(D) Fourth, ten percent of the total amount of revenues collected or deposited into the fund in the applicable year or the amount remaining in the fund, whichever is less, to carriers to reduce the costs of individual health plans for individuals who purchase an individual health benefit plan on the exchange and receive the premium tax credit.

(II) If, after making the allocations specified in subsection (2)(d)(I) of this section, there is money remaining in the fund in the applicable year, the enterprise shall allocate the remaining money for subsidies for state-subsidized individual health coverage plans purchased by qualified individuals.

(III) Notwithstanding subsections (2)(d)(I) and (2)(d)(II) of this section, if the approval of the demonstration waiver received pursuant to section 25.5-4-503 (2) sets conditions on the use of the money received, the enterprise shall allocate the money received pursuant to section 25.5-4-503 (2) as set forth in the approval. If the approval does not set conditions on the use of money received, the enterprise shall allocate the money in the manner set forth in subsections (2)(d)(I) and (2)(d)(II) of this section.

(IV) On or after August 28, 2025, the enterprise shall reallocate any amount of revenues collected and allocated pursuant to subsection (2)(d)(I) of this section that has not been expended on or before August 28, 2025, not to exceed twenty million dollars, for any other purpose specified in subsection (2)(d)(I) of this section except administrative costs described in subsection (2)(d)(I)(A) of this section.

(e) **[*Editor's note: Subsection (2)(e) is effective (see editor's note following this section).*]**

(I) On or after the date on which the state treasurer credits money to the fund in accordance with section 10-16-1206 (1.5)(a), except as provided in subsection (2)(e)(II) of this section, the

enterprise shall allocate the money credited to the fund pursuant to section 10-16-1206 (1.5)(a) as follows:

(A) Up to fifty million dollars to the reinsurance program cash fund; and

(B) Up to fifty million dollars to carriers to reduce the costs of individual health plans for individuals who purchase an individual health benefit plan on the exchange and receive the premium tax credit.

(II) The enterprise may allocate up to five million dollars of the money credited to the fund in accordance with section 10-16-1206 (1.5)(a) for any other purpose specified in subsection (2)(d)(I) of this section except administrative costs described in subsection (2)(d)(I)(A) of this section.

(III) This subsection (2)(e) takes effect on January 1, 2026, only if the condition specified in section 10-16-1209 (1) occurs.

(3) The enterprise shall distribute the allocations specified in subsection (2) of this section in accordance with the requirements determined by the board pursuant to section 10-16-1207 (4).

(4) If the commissioner, pursuant to section 10-16-1107 (4), notifies the board that the reinsurance program will receive federal funding pursuant to a federal reinsurance program or other federal financial assistance for the reinsurance program that is in excess of federal pass-through funding received pursuant to section 10-16-1107 (1)(a)(I), the enterprise may eliminate or reduce the amount of enterprise revenues allocated to the reinsurance program pursuant to subsection (2) of this section based on the amount of federal funding the reinsurance program receives, as indicated in the commissioner's notice, and shall reallocate the portion of the enterprise revenues no longer allocated to the reinsurance program to the other purposes specified in subsection (2) of this section in accordance with that subsection (2).

(5) (a) The special assessments on hospitals under subsection (1)(a)(II) of this section must comply with and not violate 42 CFR 433.68. If the federal centers for medicare and medicaid services in the United States department of health and human services informs the state that the state will not be in compliance with 42 CFR 433.68 as a result of the special assessment on hospitals pursuant to subsection (1)(a)(II) of this section, the enterprise shall reduce the amount of the special assessment as necessary to avoid any reduction in the healthcare affordability and sustainability hospital provider fee collected pursuant to section 25.5-4-402.4.

(b) A hospital shall pay the special assessment imposed pursuant to subsection (1)(a)(II) of this section from its general revenues and is prohibited from:

(I) Collecting an assessment from consumers as any type of surcharge on its fees;

(II) Passing the special assessment on to consumers as any type of increase to fees or charges for services; or

(III) Otherwise passing the special assessment on to consumers in any manner.

Source: L. 2020: Entire part added, (SB 20-215), ch. 201, p. 990, § 1, effective June 30. **L. 2022:** (2)(d)(III) added, (HB 22-1289), ch. 399, p. 2835, § 2, effective June 7. **L. 2025:** (5)(a) amended, (SB 25-270), ch. 151, p. 604, § 11, effective May 1. **L. 2025, 1st Ex. Sess.:** IP(2)(d)(I) amended and (2)(d)(IV) and (2)(e) added, (HB 25B-1006), ch. 10, p. 41, § 2, effective August 28 (see editor's note).

Editor's note: (1) (a) Section 10-16-1209 (1) provides that subsection (2)(e) is effective if, by December 31, 2025, the United States congress does not enact and the president does not sign federal legislation that extends, recreates, or otherwise reinstates the enhanced premium tax credit for the 2026 plan year, and the commissioner of insurance shall notify the revisor of statutes in writing of the date on which the condition specified has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. If the condition specified occurs, subsection (2)(e) takes effect on January 1, 2026. For more information, see HB 25B-1006 (L. 2025, 1st Ex. Sess., p. 45). As of publication date, the revisor of statutes has not received the notice referred to in § 10-16-1209 (1).

(b) Section 10-16-1209 (2) provides that subsection (2)(e) is repealed, effective if, on or before December 31, 2025, the United States congress enacts and the president signs federal legislation that extends, recreates, or otherwise reinstates the enhanced premium tax credit for the 2026 plan year with at least the same eligibility and in the same amount as authorized by the amendments to the premium tax credit in the federal "American Rescue Plan Act of 2021", Pub.L. 117-2, and the federal "Inflation Reduction Act of 2022", Pub.L. 117-169, 136 Stat. 1818 (2022), and the commissioner of insurance shall notify the revisor of statutes in writing of the date on which the condition specified has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. If the condition specified occurs, subsection (2)(e) is repealed upon the date identified in the notice or, if the notice does not specify that date, upon the date of the notice to the revisor of statutes. For more information, see HB 25B-1006 (L. 2025, 1st Ex. Sess., p. 45). As of publication date, the revisor of statutes has not received the notice referred to in § 10-16-1209 (2).

Cross references: For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

10-16-1206. Health insurance affordability cash fund - creation - repeal. (1) There is created in the state treasury the health insurance affordability cash fund. The fund consists of:

(a) The fees collected from carriers pursuant to section 10-16-1205 (1)(a)(I);

(b) The special assessments collected from hospitals pursuant to section 10-16-1205 (1)(a)(II);

(c) Repealed.

(d) The revenue collected from revenue bonds issued pursuant to section 10-16-1204 (1)(b)(II);

(e) Money that may be allocated to the fund pursuant to section 10-16-1308;

(f) All interest and income derived from the deposit and investment of money in the fund;

(g) The federal share of the medical assistance payments received pursuant to section 25.5-4-503 (2);

(h) Gifts, grants, or donations received from private or public sources; and

(i) Any other money that may be appropriated or transferred to the fund.

(1.5) **[*Editor's note: Subsection (1.5) is effective (see editor's note following this section).*]**

(a) The fund also consists of one hundred million dollars from the following sources, which the enterprise shall allocate in accordance with section 10-16-1205 (2)(e):

(I) Up to one hundred million dollars from tax credit sale proceeds credited to the fund pursuant to section 24-36-406; and

(II) (A) If the total amount of tax credit sale proceeds available for deposit in the fund is less than one hundred million dollars, an amount determined and transferred, in accordance with subsection (1.5)(a)(II)(B) of this section, from the general fund to the fund.

(B) The state treasurer shall determine the amount of the transfer from the general fund to the fund by calculating the difference between one hundred million dollars and the amount of tax credit sale proceeds credited to the fund pursuant to section 24-36-406 and, within ten days after making the determination, shall transfer that amount from the general fund to the fund.

(b) This subsection (1.5) takes effect on January 1, 2026, only if the condition specified in section 10-16-1209 (1) occurs.

(2) Money in the fund shall not be transferred to any other fund, except as provided in section 10-16-1205 (2), and shall not be used for any purpose other than the purposes specified in this part 12.

(3) All money in the fund is continuously available and appropriated to the enterprise to use in accordance with this part 12.

(4) The fund is part of the enterprise established pursuant to section 10-16-1204 (1).

(5) (a) On September 1, 2025, the state treasurer shall transfer two hundred sixty-four thousand two hundred sixty-eight dollars from the general fund to the fund.

(b) This subsection (5) is repealed, effective July 1, 2026.

Source: L. 2020: Entire part added, (SB 20-215), ch. 201, p. 994, § 1, effective June 30. **L. 2021:** (1)(d) and (1)(e) amended and (1)(f) added, (HB 21-1232), ch. 241, p. 1293, § 3, effective June 16. **L. 2022:** (1)(e) and (1)(f) amended and (1)(g) added, (HB 22-1289), ch. 399, p. 2835, § 3, effective June 7. **L. 2024:** IP(1) and (1)(c) amended, (HB 24-1470), ch. 491, p. 3446, § 1, effective June 7. **L. 2025:** (1)(f) and (1)(g) amended and (1)(h) added, (HB 25-1309), ch. 233, p. 1105, § 2, effective May 23. **L. 2025, 1st Ex. Sess.:** (1)(g) and (1)(h) amended and (1)(i) and (5) added, (SB 25B-005), ch. 4, p. 12, § 1, effective August 28; (1)(g) and (1)(h) amended and (1)(i) and (1.5) added, (HB 25B-1006), ch. 10, p. 42, § 3, effective August 28 (see editor's note).

Editor's note: (1) Subsection (1)(c)(II) provided for the repeal of subsection (1)(c), effective July 1, 2025. (See L. 2024, p. 3446.)

(2) (a) Section 10-16-1209 (1) provides that subsection (1.5) is effective if, by December 31, 2025, the United States congress does not enact and the president does not sign federal legislation that extends, recreates, or otherwise reinstates the enhanced premium tax credit for the 2026 plan year, and the commissioner of insurance shall notify the revisor of statutes in writing of the date on which the condition specified has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. If the condition specified occurs, subsection (1.5) takes effect on January 1, 2026. For more information, see HB 25B-1006 (L. 2025, 1st Ex. Sess., p. 45). As of publication date, the revisor of statutes has not received the notice referred to in § 10-16-1209 (1).

(b) Section 10-16-1209 (2) provides that subsection (1.5) is repealed, effective if, on or before December 31, 2025, the United States congress enacts and the president signs federal legislation that extends, recreates, or otherwise reinstates the enhanced premium tax credit for

the 2026 plan year with at least the same eligibility and in the same amount as authorized by the amendments to the premium tax credit in the federal "American Rescue Plan Act of 2021", Pub.L. 117-2, and the federal "Inflation Reduction Act of 2022", Pub.L. 117-169, 136 Stat. 1818 (2022), and the commissioner of insurance shall notify the revisor of statutes in writing of the date on which the condition specified has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. If the condition specified occurs, subsection (1.5) is repealed upon the date identified in the notice or, if the notice does not specify that date, upon the date of the notice to the revisor of statutes. For more information, see HB 25B-1006 (L. 2025, 1st Ex. Sess., p. 45). As of publication date, the revisor of statutes has not received the notice referred to in § 10-16-1209 (2).

Cross references: For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

10-16-1207. Health insurance affordability board - creation - membership - powers and duties - subject to open meetings and public records laws - annual report - commissioner rules. (1) (a) There is hereby created the health insurance affordability board, which board is responsible for governance of the enterprise established in this part 12. The board consists of the following eleven voting members:

(I) The executive director of the exchange or the executive director's designee;

(II) The commissioner or the commissioner's designee; and

(III) Nine members appointed by the governor, with the consent of the senate, as follows:

(A) One member who is employed by a carrier;

(B) One member who is a representative of a statewide association of health benefit plans;

(C) One member representing primary care health care providers who does not represent a carrier;

(D) Three members who are consumers of health care who are not representatives or employees of a hospital, carrier, or other health care industry entity. To the extent possible, the governor shall ensure that the consumer members of the board are individuals who lack affordable offers of coverage from their employers and otherwise struggle to afford to purchase health insurance.

(E) One member who represents a health care advocacy organization;

(F) One member who is a representative of a business that purchases or otherwise provides health insurance for its employees; and

(G) One member who represents a rural, critical access, or independent hospital.

(b) To the extent possible, the governor shall attempt to appoint board members who reflect the diversity of the state with regard to race, ethnicity, immigration status, income, wealth, ability, and geography. In considering geographic diversity, the governor shall ensure at least one member resides on the eastern plains and one member resides on the western slope and, to the extent possible, shall attempt to appoint members from each congressional district in the state.

(c) The governor shall make initial appointments to the board by October 1, 2020.

(2) (a) (I) Except as provided in subsection (2)(a)(II) of this section, the term of office of the members of the board appointed by the governor is four years, and those members may serve no more than two four-year terms.

(II) In order to ensure staggered terms of office, the initial term of office of the members of the board is:

(A) Two years for the members appointed pursuant to subsections (1)(a)(III)(A), (1)(a)(III)(C), and (1)(a)(III)(F) of this section and for two of the members appointed pursuant to subsection (1)(a)(III)(D) of this section; and

(B) Four years for the members appointed pursuant to subsections (1)(a)(III)(B), (1)(a)(III)(E), and (1)(a)(III)(G) of this section and for one of the members appointed pursuant to subsection (1)(a)(III)(D) of this section.

(b) Members of the board appointed by the governor serve at the pleasure of the governor and may be removed by the governor.

(c) A member who is appointed to fill a vacancy shall serve the remainder of the unexpired term of the member whose vacancy is being filled.

(d) Members of the board may be reimbursed for actual and necessary expenses, including any required dependent care and dependent or attendant travel, food, and lodging, while engaged in the performance of official duties of the board.

(3) The board shall meet as often as necessary to carry out its duties pursuant to this part 12.

(4) The board is authorized to:

(a) Implement and administer the enterprise;

(b) Establish administrative and accounting procedures for the operation of the enterprise;

(c) Recommend, for approval and establishment by the commissioner by rule:

(I) The timing and methodology for assessing and collecting the fee and special assessment, subject to section 10-16-1205 (1)(a);

(II) The distribution of enterprise revenues allocated for carrier payments and subsidies in a manner that improves affordability for subsidized populations and individuals not eligible for the premium tax credit, medicaid, medicare, or the children's basic health plan;

(III) The payments authorized by this part 12 to be made to carriers to reduce the costs of individual health plans for individuals who purchase an individual health benefit plan on the exchange and receive the premium tax credit; and

(IV) The parameters for implementing the subsidies for state-subsidized individual health coverage plans authorized by this part 12, including:

(A) Repealed.

(B) The criteria and procedures for determining whether an individual is a qualified individual eligible to enroll in a state-subsidized individual health coverage plan;

(c.5) Further recommend, for approval and establishment by the commissioner by rule, additional parameters for implementing the subsidies for state-subsidized individual health coverage plans authorized by this part 12, including that the coverage required pursuant to state-subsidized individual health coverage plans must:

(I) Maximize affordability for qualified individuals;

(II) Cover benefits equivalent to those in a qualified health plan; and

(III) For a person who, at the time the person applies for state-subsidized coverage, meets the income requirements to qualify for emergency medical assistance pursuant to section 25.5-5-103 and who is a qualified individual who meets the eligibility criteria established in rule pursuant to subsection (4)(c)(IV) of this section, include coverage and plan design that:

(A) Maximizes enrollment in the plan; and

(B) To the extent possible with available funding, includes cost sharing such that the plan has consumer cost-sharing responsibilities for emergency services equivalent to cost-sharing responsibilities for emergency medical assistance pursuant to section 25.5-5-103;

(d) Establish bylaws, as appropriate and consistent with this part 12, for its effective operation; and

(e) Seek, accept, and expend gifts, grants, or donations from private or public sources that the enterprise may use for any of the purposes set forth in section 10-16-1205, to cover the costs of ensuring compliance in the individual market with the federal Hyde amendment or a similar amendment, and to cover the costs of ensuring that Coloradans have access to legally protected health-care activities, as defined in section 12-30-121 (1)(d). The enterprise shall consider the feasibility of allocating gifts, grants, or donations received from specific localities or directed to specific localities to be used only in those localities.

(4.5) Prior to making any final recommendation pursuant to subsection (4) of this section regarding plans, coverage, and the number of eligible slots, the board shall seek input and recommendations from individuals directly affected by programs funded by the enterprise and shall discuss any input and recommendations received at a board meeting held in accordance with subsection (6) of this section. The board shall provide opportunities for individuals to provide input and recommendations in English and Spanish.

(5) The commissioner shall adopt rules necessary for the administration and implementation of this part 12. In adopting the rules, the commissioner shall consider the recommendations of the board and shall express in writing the reasons for any deviation from the board recommendations.

(6) Meetings of the board are subject to the open meetings provisions of the "Colorado Sunshine Act of 1972", contained in part 4 of article 6 of title 24. Except as otherwise provided in the "Colorado Open Records Act", part 2 of article 72 of title 24, or other applicable state or federal law, records of the board and the program are subject to the "Colorado Open Records Act".

(7) (a) By February 15, 2026, and by every February 15 thereafter, the board shall prepare a report detailing:

(I) The total revenue received by the enterprise in the previous calendar year;

(II) The share of the total revenue that was received from federal funds;

(III) The share of the total revenue that was received from the fee;

(IV) If any additional amount of the total revenue was received from any sources other than the federal government or the fee, the specific source of those revenues and the specific amount of revenues for each source;

(V) Each specific program that received funding from the enterprise;

(VI) Of the total allocation for each program:

(A) The share of the total allocation that was from federal funding; and

(B) The share of the total allocation that was from state funding and the source of that state funding;

(VII) For the reinsurance program, the amount of the actual allocation of state money to the reinsurance program;

(VIII) If less than the maximum allowable allocation of state money in the fund was allocated to the reinsurance program, an explanation of why the reinsurance program was not fully funded;

(IX) For any allocation that was made at the discretion of the board or commissioner and not defined expressly in statute, an explanation of the allocations, the amount of each allocation, the rationale for the amounts, and the goals intended to be achieved as a result of each allocation; and

(X) The amount of surplus in the fund, if any, and an explanation of why the surplus was not allocated to enterprise programs.

(b) By February 28, 2026, and by each February 28 thereafter:

(I) The board shall submit the report to the house of representatives health and human services committee and the senate health and human services committee, or their successor committees, and the joint budget committee; and

(II) The division shall post the report on the division's public-facing website in an easily accessible location and manner.

(c) Notwithstanding the requirement in section 24-1-136 (11)(a)(I), the requirement to submit the report specified in this subsection (7) continues indefinitely.

Source: L. 2020: Entire part added, (SB 20-215), ch. 201, p. 995, § 1, effective June 30. **L. 2022:** (4)(c)(IV)(A) repealed and (4)(c.5) added, (HB 22-1289), ch. 399, p. 2835, § 5, effective June 7. **L. 2025:** (4)(c.5)(III)(C) and (4)(d) amended and (4)(e) added, (HB 25-1309), ch. 233, p. 1106, § 3, effective May 23. **L. 2025, 1st Ex. Sess.:** (4)(c.5)(III) amended and (4.5) and (7) added, (HB 25B-1006), ch. 10, p. 43, § 4, effective August 28.

Cross references: For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

10-16-1208. Limitation on authority - public option. Nothing in this part 12 authorizes the enterprise, the board, or the commissioner to establish, administer, operate, or require participation by carriers or hospitals in a state or public option health coverage plan.

Source: L. 2020: Entire part added, (SB 20-215), ch. 201, p. 997, § 1, effective June 30.

10-16-1209. Repeal of certain provisions - notice to the revisor - repeal. (1) Sections 10-16-1205 (2)(e), 10-16-1206 (1.5), and 24-75-201.1 (1)(d)(XXVII)(A) will take effect only if, by December 31, 2025, the United States congress does not enact and the president does not sign federal legislation that extends, recreates, or otherwise reinstates the enhanced premium tax credit for the 2026 plan year. The commissioner shall notify the revisor of statutes in writing if the condition specified in this subsection (1) has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. If the condition specified in this subsection (1) occurs, sections 10-16-1205 (2)(e), 10-16-1206 (1.5), and 24-75-201.1 (1)(d)(XXVII)(A) take effect on January 1, 2026.

(2) This section and sections 10-16-1205 (2)(e), 10-16-1206 (1.5), and 24-75-201.1 (1)(d)(XXVII)(A) will be repealed if, on or before December 31, 2025, the United States congress enacts and the president signs federal legislation that extends, recreates, or otherwise reinstates the enhanced premium tax credit for the 2026 plan year with at least the same eligibility and in the same amount as authorized by the amendments to the premium tax credit in the federal "American Rescue Plan Act of 2021", Pub.L. 117-2, and the federal "Inflation Reduction Act of 2022", Pub.L. 117-169, 136 Stat. 1818 (2022). The commissioner shall notify the revisor of statutes in writing if the condition specified in this subsection (2) has occurred and of the date on which the condition occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. This section and sections 10-16-1205 (2)(e), 10-16-1206 (1.5), and 24-75-201.1 (1)(d)(XXVII)(A) are repealed upon the date identified in the notice that the condition specified in this subsection (2) occurred or, if the notice does not specify that date, upon the date of the notice to the revisor of statutes.

Source: L. 2025, 1st Ex. Sess.: Entire section added, (HB 25B-1006), ch. 10, p. 45, § 5, effective August 28.

Editor's note: As of publication date, the revisor of statutes has not received the notice referred to in subsection (1) or the notice referred to in subsection (2). This section and sections 10-16-1205 (2)(e), 10-16-1206 (1.5), and 24-75-201.1 (1)(d)(XXVII)(A) are repealed upon the date identified in the notice that the condition specified in subsection (2) occurred or, if the notice does not specify that date, upon the date of the notice to the revisor of statutes.

10-16-1210. Regulatory agenda - division review of regulation - repeal. (1) (a) The division shall conduct a review of regulation 4-2-76, concerning the health insurance affordability fee assessment and collection process, codified in 3 CCR 702-4, in accordance with section 24-4-103.3. The department of regulatory agencies shall include the division's review of regulation 4-2-76 in its departmental regulatory agenda that the department submits to the staff of the legislative council in accordance with section 2-7-203 (4) by November 1, 2026. The health and human services committees of the house of representatives and the senate are the applicable committees of reference to which the staff of the legislative council shall distribute the review of regulation 4-2-76.

(b) The division shall make a presentation of its review, as part of the departmental presentations to the committees in accordance with section 2-7-203, in the 2027 regular legislative session.

(2) This section is repealed, effective July 1, 2027.

Source: L. 2025, 1st Ex. Sess.: Entire section added, (HB 25B-1006), ch. 10, p. 45, § 5, effective August 28.

10-16-1211. Performance audit of the enterprise - repeal. (1) By December 31, 2027, the state auditor shall complete a performance audit of the enterprise. In conducting the audit, the state auditor shall:

(a) Determine whether the enterprise and the board are in compliance with the purpose and responsibilities of the enterprise and the board as specified in sections 10-16-1202, 10-16-1204, 10-16-1205, and 10-16-1207;

(b) Specify, for each year since the creation of the enterprise:

(I) The annual revenue deposited in the fund from:

(A) The fee collected from carriers pursuant to section 10-16-1205 (1)(a)(I);

(B) The special assessments collected from hospitals pursuant to section 10-16-1205 (1)(a)(II);

(C) Premium tax revenues deposited in the fund pursuant to section 10-3-209 (4)(a)(III) before its repeal on July 1, 2025;

(D) Money allocated to the fund pursuant to section 10-16-1308;

(E) The federal share of the medical assistance payments received pursuant to section 25.5-4-503 (2);

(F) Any revenue collected from revenue bonds pursuant to section 10-16-1204 (1)(b)(II);

(G) Interest and income derived from the deposit and investment of money in the fund; and

(H) Any gifts, grants, or donations received from private or public sources;

(II) The annual expenditures from the fund for the purposes specified in section 10-16-1205 (1)(b), indicating the amounts expended in each year for each of the following purposes and the amount of such expenditures that was paid from revenues described in subsections (1)(b)(I)(D) and (1)(b)(I)(E) of this section:

(A) To provide funding for the reinsurance program;

(B) To provide payments to carriers to increase the affordability of health insurance on the individual market for Coloradans who receive the premium tax credit;

(C) To provide subsidies for state-subsidized individual health coverage plans purchased by qualified individuals;

(D) To pay the enterprise's actual administrative costs to implement and administer this part 12; and

(E) To pay the costs of consumer enrollment, outreach, and education activities regarding health-care coverage; and

(III) The amount of revenues allocated or otherwise designated for a purpose specified in section 10-16-1205 (1)(b) that the enterprise did not encumber or expend;

(c) With regard to the allocation of revenues to the reinsurance program:

(I) Determine, for each year since the enterprise collected or received revenues, whether the enterprise allocated to the reinsurance program cash fund the maximum allowable amount of revenues as specified in section 10-16-1205 (2); and

(II) For any year in which the enterprise did not allocate the maximum allowable amount of revenues to the reinsurance program, analyze:

(A) The enterprise's and the division's rationale for not allocating the maximum allowable amount of revenues to the reinsurance program; and

(B) The impact of that decision on the affordability relief provided to consumers in the individual market and the ability of the enterprise to fund other programs authorized in this part 12;

(d) Determine whether the enterprise's current and projected revenues are sufficient for the enterprise to efficiently and effectively fulfill its duties and responsibilities as specified in this part 12; and

(e) Determine the significance of federal funding on the ability of the enterprise to efficiently and effectively fulfill its duties and responsibilities as specified in this part 12.

(2) Upon completion of the performance audit required by subsection (1) of this section, the state auditor shall submit a written report about the performance audit to the legislative audit committee and to the health and human services committees of the senate and the house of representatives.

(3) This section is repealed, effective December 31, 2028.

Source: L. 2025, 1st Ex. Sess.: Entire section added, (HB 25B-1006), ch. 10, p. 46, § 5, effective August 28.

PART 13

COLORADO STANDARDIZED HEALTH BENEFIT PLAN

10-16-1301. Short title. The short title of this part 13 is the "Colorado Standardized Health Benefit Plan Act".

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1278, § 1, effective June 16.

10-16-1302. Legislative declaration - intent. (1) The general assembly, through the exercise of its powers to protect the health, peace, safety, and general welfare of the people of Colorado, hereby finds that:

(a) Health insurance coverage has been demonstrated to have a positive impact on people's health outcomes as well as their financial security and well-being;

(b) Ensuring that all people have access to affordable, quality, continuous, and equitable health care is a challenge that public officials and policy experts have faced for decades despite seemingly constant efforts to address the issue;

(c) Although great strides have been made in increasing access to health-care coverage through federal and state legislation, not enough has been accomplished to address the affordability of health insurance in Colorado, particularly in the state's rural areas and for Coloradans who have historically and systemically faced barriers to health, including people of color, immigrants, and Coloradans with low incomes;

(d) The health-care system is a complex system wherein consumers rely on health insurance carriers to negotiate the rates paid to health-care providers, pharmaceutical companies, and hospitals for services provided and expect that the negotiated rates are closely tied to the amount of the health insurance premiums paid;

(e) Despite efforts to address access to and affordability of health care, underlying health-care costs continue to rise, thus driving up the costs of health insurance premiums, often at disproportionate rates in rural areas of the state; and

(f) In order to ensure that health insurance is affordable for Coloradans, it is critical that the state establish a standardized plan for carriers to offer in the state and set premium reduction targets for carriers to achieve.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1278, § 1, effective June 16.

10-16-1303. Definitions. As used in this part 13, unless the context otherwise requires:

(1) "Advisory board" means the board established in section 10-16-1307.

(2) "Critical access hospital" means a hospital that is federally certified or undergoing federal certification as a critical access hospital pursuant to 42 CFR 485, subpart F.

(3) (a) "Equivalent rate" means, for a hospital that is part of a pediatric specialty hospital system where over ninety percent of the hospital system's population served is under eighteen years of age and that has a level one pediatric trauma center, the payment rate determined by the medicaid fee schedule for the hospital from the most recent year for which a complete set of hospital financial data is publicly available as of May 10, 2023, multiplied by a conversion factor equal to the ratio of the statewide payment-to-cost ratio for medicare to the hospital's specific payment-to-cost ratio for the most recent set of publicly available hospital financial data as of May 10, 2023, which is 1.52.

(b) In any given year, the rate in subsection (3)(a) of this section must be adjusted annually for cumulative inflation by a factor equal to the average percentage increase in the medicare inpatient and outpatient prospective payment systems over the previous three years.

(c) For any health-care service without an existing medicare reimbursement rate and for services that have low volume statewide relative to other medicare services, including pediatric or obstetric services, an equivalent rate means a rate set by rule of the commissioner after consultation with a statewide association of hospitals, physicians, other providers, and the department of health care policy and financing. The equivalent rate must utilize the ratio of medicaid payment rates to existing medicare payment rates whenever possible.

(4) "Essential access hospital" means a critical access hospital or general hospital located in a rural area with twenty-five or fewer licensed beds.

(5) "Essential community provider" has the same meaning as set forth in section 25.5-8-103 (6).

(6) "General hospital" means a hospital licensed as a general hospital by the Colorado department of public health and environment.

(7) "Health-care coverage cooperative" has the same meaning as set forth in section 10-16-1002 (2).

(8) "Health-care provider" means a health-care professional registered, certified, or licensed pursuant to title 12 or a health facility licensed or certified pursuant to section 25-1.5-103.

(9) "Health system" means a corporation or other organization that owns, contains, or operates three or more hospitals.

(10) "Medical inflation" means the annual percentage change in the medical care index component of the United States department of labor's bureau of labor statistics consumer price index for medical care services and medical care commodities for the Denver-Aurora-Lakewood

area, or its applicable predecessor or successor index, based on the average change in the medical care index over the previous three years.

(11) (a) "Medicare reimbursement rate" means the facility-specific reimbursement rate for a particular health-care service provided under the "Health Insurance for the Aged Act", Title XVIII of the federal "Social Security Act", 42 U.S.C. sec. 1395 et seq., as amended.

(b) For a hospital that is reimbursed through the medicare prospective payments systems rate for a critical access hospital, "medicare reimbursement rate" means the rate based on allowable costs as reported in medicare cost reports and the historical cost-to-charge ratios for the specific hospital.

(12) "Public benefit corporation" means a public benefit corporation formed pursuant to part 5 of article 101 of title 7 that may be organized and operated by the exchange pursuant to section 10-22-106 (3).

(13) "Small group market" means the market for small group sickness and accident insurance.

(14) "Standardized plan" means the standardized health benefit plan designed by rule of the commissioner pursuant to section 10-16-1304.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1279, § 1, effective June 16. **L. 2023:** (3)(a) and (10) amended, (HB 23-1224), ch. 159, p. 689, § 1, effective May 10.

10-16-1304. Standardized health benefit plan - established - components - rules - independent analysis - repeal. (1) On or before January 1, 2022, the commissioner shall establish, by rule, a standardized health benefit plan to be offered by carriers in this state in the individual and small group markets. The standardized plan must:

(a) Offer health-care coverage at the bronze, silver, and gold levels of coverage as described in section 10-16-103.4;

(b) Include, at a minimum, pediatric and other essential health benefits;

(c) Be offered through the exchange and in the individual market through the public benefit corporation;

(d) Be a standardized benefit design that:

(I) Is created through a stakeholder engagement process that includes physicians, health-care industry and consumer representatives, individuals who represent health-care workers or who work in health care, and individuals working in or representing communities that are diverse with regard to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic regions of the state and that are affected by higher rates of health disparities and inequities;

(II) Has a defined benefit design and cost-sharing that improves access and affordability; and

(III) Is designed to improve racial health equity and decrease racial health disparities through a variety of means, which are identified collaboratively with consumer stakeholders, including:

(A) Improving perinatal health-care coverage; and

(B) Providing first-dollar, predeductible coverage for certain high-value services, such as primary and behavioral health care;

(e) Be actuarially sound and allow a carrier to continue to meet the financial requirements in article 3 of this title 10;

(f) Comply with the federal act, including the risk adjustment requirements under 45 CFR 153, and this article 16; and

(g) Have a network that is:

(I) Culturally responsive and, to the greatest extent possible, reflects the diversity of its enrollees in terms of race, ethnicity, gender identity, and sexual orientation in the area that the network exists; and

(II) No more narrow than the most restrictive network the carrier is offering for nonstandardized plans in the individual market for the metal tier for that rating area.

(2) (a) In developing the network for the standardized plan pursuant to subsection (1)(g) of this section, each carrier shall:

(I) Include as part of its network access plan a description of the carrier's efforts to construct diverse, culturally responsive networks that are well-positioned to address health equity and reduce health disparities; and

(II) Include a majority of the essential community providers in the service area in its network.

(b) If a carrier is unable to achieve the network adequacy requirements in subsection (1)(g) of this section, the carrier shall file an action plan with the division that describes the carrier's efforts to achieve the requirements in subsection (1)(g) of this section.

(c) The commissioner shall promulgate rules regarding the network adequacy requirements in subsection (1)(g) of this section and the action plan in subsection (2)(b) of this section.

(3) (a) The standardized plan must be offered in a manner that allows consumers to easily compare the standardized plans offered by each carrier.

(b) The exchange, in collaboration with the commissioner and after a stakeholder engagement process with consumers, producers, and carriers, shall develop a format for displaying the standardized plans on the exchange in a manner that allows for standardized plans to be easily identified and compared.

(4) The commissioner may update the standardized plan annually by rule through the stakeholder process described in subsection (1)(d)(I) of this section.

(5) The commissioner shall contract with an independent third party to conduct an analysis of the impact of this section on health plan enrollment, health insurance affordability, and health equity. To the extent available, the analysis must include disaggregated data by race, ethnicity, immigration status, sexual orientation, gender identity, age, and ability. If the data is not available, the analysis must note such unavailability. The analysis must include information concerning total out-of-pocket health-care spending. The analysis must be completed on or before January 1, 2026.

(6) (a) The commissioner shall collaborate with the exchange concerning the survey required in section 10-22-114, which survey addresses consumers' experience.

(b) This subsection (6) is repealed, effective July 1, 2026.

(7) The commissioner is not required to comply with the "Procurement Code", articles 101 to 112 of title 24, for the purposes of this section.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1281, § 1, effective June 16. **L. 2023:** (3) amended, (HB 23-1224), ch. 159, p. 690, § 2, effective May 10.

10-16-1305. Standardized health benefit plan - carriers required to offer - premium rates - rules. (1) Beginning January 1, 2023, a carrier that offers:

(a) An individual health benefit plan in Colorado is required to offer the standardized plan in the individual market in each county where the carrier offers an individual health benefit plan and shall offer the standardized plan throughout the entire county; and

(b) A small group health benefit plan in Colorado is required to offer the standardized plan in the small group market in each county where the carrier offers a small group health benefit plan and shall offer the standardized plan throughout the entire county.

(2) (a) (I) In the individual market, for the plan year beginning January 1, 2023, and in the small group market, beginning January 1, 2023, each carrier shall offer the standardized plan at a premium rate that is at least five percent less than the premium rate for health benefit plans that the carrier offered in the 2021 calendar year, as adjusted for medical inflation, in the individual and small group markets. The commissioner shall calculate the premium rate reduction based on the rates charged in the same county in which the carrier offered health benefit plans in the individual and small group markets in 2021 prior to the application of the Colorado reinsurance program pursuant to part 11 of this article 16.

(II) For carriers offering the standardized plan in the 2023 plan year in a county in which the carrier did not offer a health benefit plan in the individual or small group market in the 2021 calendar year, each carrier that offers the standardized plan shall offer the standardized plan:

(A) In the individual market at a premium rate that is at least five percent less than the average premium rate for individual health benefit plans offered in that county in 2021, calculated based on the average premium rate for individual health benefit plans offered in that county, as adjusted for medical inflation, prior to the application of the Colorado reinsurance program pursuant to part 11 of this article 16; and

(B) In the small group market at a premium rate that is at least five percent less than the average premium rate for small group plans offered in that county in 2021, as adjusted for medical inflation.

(b) (I) In the individual market, for the plan year beginning January 1, 2024, and in the small group market, beginning January 1, 2024, each carrier shall offer the standardized plan at a premium rate that is at least ten percent less than the premium rate for health benefit plans that the carrier offered in the 2021 calendar year, as adjusted for medical inflation, in the individual and small group markets. The commissioner shall calculate the premium rate reduction based on the rates charged in the same county in which the carrier offered health benefit plans in the individual and small group markets in 2021 prior to the application of the Colorado reinsurance program pursuant to part 11 of this article 16.

(II) For carriers offering the standardized plan in the 2024 plan year in a county in which the carrier did not offer a health benefit plan in the individual or small group market in the 2021 calendar year, each carrier that offers the standardized plan shall offer the standardized plan:

(A) In the individual market at a premium rate that is at least ten percent less than the average premium rate for individual plans offered in that county in 2021, calculated based on the average premium rate for individual plans offered in that county, as adjusted for medical

inflation, prior to the application of the Colorado reinsurance program pursuant to part 11 of this article 16; and

(B) In the small group market at a premium rate that is at least ten percent less than the average premium rate for small group plans offered in that county in 2021, as adjusted for medical inflation.

(c) (I) In the individual market, for the plan year beginning January 1, 2025, and in the small group market, beginning January 1, 2025, each carrier shall offer the standardized plan at a premium rate that is at least fifteen percent less than the premium rate for health benefit plans that the carrier offered in the 2021 calendar year, as adjusted for medical inflation, in the individual and small group markets. The commissioner shall calculate the premium rate reduction based on the rates charged in the same county in which the carrier offered health benefit plans in the individual and small group markets in 2021 prior to the application of the Colorado reinsurance program pursuant to part 11 of this article 16.

(II) For carriers offering the standardized plan in the 2025 plan year in a county in which the carrier did not offer a health benefit plan in the individual or small group market in the 2021 calendar year, each carrier that offers the standardized plan shall offer the standardized plan:

(A) In the individual market at a premium rate that is at least fifteen percent less than the average premium rate for individual plans offered in that county in 2021, calculated based on the average premium rate for individual plans offered in that county, as adjusted for medical inflation, prior to the application of the Colorado reinsurance program pursuant to part 11 of this article 16; and

(B) In the small group market at a premium rate that is at least fifteen percent less than the average premium rate for small group plans offered in that county in 2021, as adjusted for medical inflation.

(d) For the plan year beginning on or after January 1, 2026, and each year thereafter, each carrier and health-care coverage cooperative shall limit any annual percentage increase in the premium rate for the standardized plan in both the individual and small group markets to a rate that is no more than medical inflation, relative to the previous year.

(3) The premium rate requirements in subsections (2)(a), (2)(b), and (2)(c) of this section for the standardized plan offered in the individual and small group markets must account for policy adjustments adopted consistent with the requirements in section 10-16-107 (8) to prevent people with low and moderate incomes from experiencing net increases in premium costs, such as adopting the induced demand factors utilized as part of the federal risk adjustment program under 42 U.S.C. sec. 18063.

(4) The commissions paid to insurance producers for the sale of the standardized plan must be comparable to the average commissions paid for the sale of other plans offered in the individual and small group markets.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1283, § 1, effective June 16.

10-16-1305.5. Rate filings. (1) In the rate filings required pursuant to section 10-16-107, each carrier must file rates for the standardized plan at the premium rates required in section 10-16-1305 (2).

(2) In reviewing the rates for the standardized plans, the commissioner may establish uniform limits on all carriers' administrative costs and profits for a standardized plan if the resulting premium rates are actuarially sound and do not entail cost shifting to plans other than standardized plans.

Source: L. 2023: Entire section added, (HB 23-1224), ch. 159, p. 690, § 3, effective May 10.

10-16-1306. Failure to meet premium rate requirements - notice - public hearing - rules.

(1) (a) Repealed.

(b) If a carrier or health-care provider anticipates that the carrier will be unable to meet network adequacy standards or the premium rate requirements in section 10-16-1305 due to a reimbursement rate dispute for the standardized plan, the carrier or health-care provider may initiate nonbinding arbitration prior to filing rates for the standardized plan. The rate filing deadline issued by the commissioner pursuant to section 10-16-107 must still be met and may not be delayed due to arbitration. The commissioner shall not be required to participate or otherwise manage any nonbinding arbitration implemented under this section.

(2) If a carrier is unable to offer the standardized plan as required by section 10-16-1305 (1) at the premium rate required in section 10-16-1305 (2) in any year, the carrier, by March 1 of the year preceding the year in which the premium rates go into effect, shall:

(a) Notify the commissioner of the reasons why the carrier is unable to meet the requirements and the steps the carrier will take to meet the premium rate requirements; and

(b) Provide to the commissioner any supporting documentation related to the hospital or health-care provider that the carrier claims is a cause for the carrier's failure to meet the premium rate requirements.

(3) (a) If, on or after January 1, 2023, and pursuant to subsection (2) of this section, a carrier notifies the commissioner that the carrier is unable to offer the standardized plan at the premium rate required in section 10-16-1305 (2) or the commissioner otherwise determines, with support from an independent actuary and based on a review of the notification submitted pursuant to subsection (2) of this section or the rate and form filings, that a carrier has not met the premium rate requirements in section 10-16-1305 (2) or the network adequacy requirements, the division may hold a public hearing prior to the approval of the carrier's final rates; except that, for the purposes of holding a public hearing, if a carrier does not meet the network adequacy requirements in section 10-16-1304 (1)(g), the commissioner shall consider a carrier to have met network adequacy requirements if the carrier files the action plan required in section 10-16-1304 (2)(b). A public hearing held pursuant to this subsection (3)(a) must be conducted in accordance with subsection (3)(c) of this section and the rules promulgated pursuant to such subsection. The public hearing is not subject to section 24-4-105 except for subsections (13), (14), and (15) of such section.

(b) Information submitted by a party for purposes of a public hearing held pursuant to subsection (3)(a) of this section is subject to the "Colorado Open Records Act", part 2 of article 72 of title 24.

(c) (I) The commissioner shall give notice of the public hearing to the carriers, hospitals, health-care providers, insurance ombudsman, and public at least fifteen days prior to the date of the hearing.

(II) The commissioner shall establish by rule:

(A) The manner in which the commissioner will notify the parties specified in subsection (3)(c)(I) of this section and interested persons of the public hearings;

(B) The manner in which the public may participate in public hearings. The commissioner shall limit the public comment and evidence presented at the hearing to information that is related to the reason the carrier failed to meet the network adequacy requirements or the premium rate requirements in section 10-16-1305 for the standardized plan in any single county.

(C) The manner in which documents must be served on the parties;

(D) The manner in which a carrier shall notify the division and affected hospitals, health-care providers, and the insurance ombudsman of a carrier's failure to meet the network adequacy requirements or the premium rate requirements in section 10-16-1305;

(E) The time frames within which the parties will be given the opportunity to submit a complaint and answer and any other necessary pleadings for the hearing;

(F) The manner in which the carrier, affected health-care providers, affected hospitals, the insurance ombudsman, and any other person the commissioner determines may be aggrieved by the commissioner's action may present evidence, examine and cross-examine witnesses, and offer oral and written arguments at the hearing;

(G) The procedures for keeping requested information confidential and for handling confidential information; and

(H) Any other matter the commissioner deems necessary for the implementation of the public hearings.

(III) The commissioner may issue procedural orders during the public hearing process to facilitate the efficient operation of the public hearing, including ordering the consolidation of proceedings involving the same carrier, hospitals, or health-care providers in counties in the same geographic rating area as established by the commissioner pursuant to section 10-16-107 (5) and the limitation of discovery.

(d) The office of the insurance ombudsman established in section 25.5-1-131 shall participate in the public hearings and represent the interests of consumers.

(4) Based on evidence presented at a hearing held pursuant to subsection (3) of this section and other available data and actuarial analysis, the commissioner may:

(a) (I) Establish carrier reimbursement rates under the standardized plan for hospital services, if necessary, to meet network adequacy requirements or the premium rate requirements in section 10-16-1305.

(II) The base reimbursement rate for hospital services shall not be less than one hundred fifty-five percent of the hospital's medicare reimbursement rate or equivalent rate.

(III) A hospital that is an essential access hospital or that is independent and not part of a health system must receive a twenty-percentage-point increase in the base reimbursement rate.

(IV) A hospital that is an essential access hospital that is not part of a health system must receive a forty-percentage-point increase in the base reimbursement rate.

(V) A hospital that is part of a pediatric specialty hospital system where over ninety percent of the health system's population served is under eighteen years of age and that has a

level one pediatric trauma center must receive a fifty-five-percentage-point increase in the base reimbursement rate and is not eligible for additional factors under this subsection (4).

(VI) A hospital with a combined percentage of patients who receive services through programs established through the "Colorado Medical Assistance Act", articles 4 to 6 of title 25.5, or medicare, Title XVIII of the federal "Social Security Act", as amended, that exceeds the statewide average must receive up to a thirty-percentage-point increase in its base reimbursement rate, with the actual increase to be determined based on the hospital's percentage share of such patients.

(VII) A hospital that is efficient in managing the underlying cost of care as determined by the hospital's total margins, operating costs, and net patient revenue must receive up to a forty-percentage-point increase in its base reimbursement rate.

(VIII) Notwithstanding subsections (4)(a)(III) to (4)(a)(VII) of this section, in determining the reimbursement rates for hospitals, the commissioner may consult with employee membership organizations representing health-care providers' employees in Colorado and with hospital-based health-care providers in Colorado, and shall take into account the cost of adequate wages, benefits, staffing, and training for health-care employees to provide continuous quality care.

(b) Establish reimbursement rates under the standardized plan, if necessary, for health-care providers for categories of services within the geographic service area for the standardized plan to meet network adequacy requirements or the premium rate requirements in section 10-16-1305 (2), which rates may not be less than one hundred thirty-five percent of the medicare reimbursement rates within the applicable geographic region for the same services;

(c) Require hospitals that are licensed pursuant to section 25-1.5-103 to accept the reimbursement rates established pursuant to subsection (4)(a) of this section if necessary to ensure the standardized plan meets the premium rate requirements and the network adequacy requirements;

(d) (I) Require health-care providers to accept the reimbursement rates established pursuant to subsection (4)(b) of this section, if necessary, to ensure the standardized plan meets the premium rate requirements and the network adequacy requirements.

(II) The commissioner shall not require a health-care provider, other than a hospital that provides a majority of covered professional services through a single, contracted medical group for a nonprofit, nongovernmental health maintenance organization, to contract with any other carrier.

(e) Require the carrier to offer the standardized plan in specific counties where no carrier is offering the standardized plan in that plan year in either the individual or small group market. In determining whether the carrier is required to offer the standardized plan in a specific county, the commissioner shall consider:

(I) The carrier's structure, the number of covered lives the carrier has in all lines of business in each county, and the carrier's existing service areas; and

(II) Alternative health-care coverage available in each county, including health-care coverage cooperatives.

(5) Notwithstanding subsection (4) of this section, the commissioner shall not set the reimbursement rates for:

(a) A hospital at less than one hundred sixty-five percent of the medicare reimbursement rate or the equivalent rate; and

(b) Any hospital for any plan year at an amount that is more than twenty percent lower than the rate negotiated between the carrier and the hospital for the previous plan year.

(6) (a) The commissioner shall promulgate rules to ensure that there is not an unfair competitive advantage for a carrier that intends to offer the standardized plan in the individual or small group market in a county where it has not previously offered health benefit plans in that market or with a hospital with which the carrier has not previously had a contract.

(b) The rules promulgated pursuant to this subsection (6) must align with the hospital reimbursement methodologies described in subsections (4) and (5) of this section.

(7) Notwithstanding subsections (4) and (5) of this section, for a hospital with a negotiated reimbursement rate that is at least ten percent less than the statewide hospital median reimbursement rate measured as a percentage of medicare for the 2021 plan year using data from the Colorado all-payer health claims database described in section 25.5-1-204, the commissioner shall set the reimbursement rate for that hospital at no less than the greater of:

(a) The hospital's commercial reimbursement rate as a percentage of medicare minus one-third of the difference between the hospital's 2021 commercial reimbursement rate as a percentage of medicare and the rate established by subsection (4) of this section;

(b) One hundred sixty-five percent of the hospital's medicare reimbursement rate or equivalent rate; or

(c) The rate established by subsection (4) of this section.

(8) A carrier or health-care provider may appeal a decision by the commissioner made pursuant to subsection (4) of this section to the Colorado court of appeals. The decision of the commissioner is a final agency action subject to judicial review pursuant to section 24-4-106 (11).

(9) For the purpose of making the determination in subsection (3) of this section:

(a) A health-care coverage cooperative, and a carrier offering health benefit plans under agreement with the health-care coverage cooperative, that has offered one or more health benefit plans to purchasers in the individual and small group markets that previously achieved and maintained at least a fifteen percent reduction in premium rates, regardless of the first year the health benefit plans were offered, shall be deemed by the commissioner as having met the requirements for carriers in sections 10-16-1304 and 10-16-1305 with respect to the counties in which the individual and small group plans are being offered by the health-care coverage cooperative.

(b) The commissioner shall take into account:

(I) Any actuarial differences between the standardized plan and the health benefit plans the carrier offered in the 2021 calendar year;

(II) Any changes to the standardized plan; and

(III) State or federal health benefit coverage mandates implemented after the 2021 plan year.

(10) A hospital or a health-care provider in Colorado shall not balance bill consumers enrolled in the standardized plan for services covered by the standardized plan and shall accept the reimbursement rates established by the commissioner pursuant to subsection (4) of this section, if applicable, for the service provided to the consumer.

(11) (a) The commissioner shall only set reimbursement rates pursuant to this section for hospitals or health-care providers that:

(I) Prevented a carrier from meeting the premium rate requirements for a standardized plan being offered in a specific county; or

(II) Caused the carrier to fail to meet network adequacy requirements.

(b) The carrier shall provide the commissioner with reasonable information necessary to identify which hospitals or health-care providers were the cause of the carrier's failure to meet the premium rate requirements or to meet network adequacy requirements.

(12) The commissioner shall not use the failure of a carrier to meet the premium rate requirements for the standardized plan in a county as a reason to deny premium rates for a nonstandardized plan of a carrier in that county.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1285, § 1, effective June 16. **L. 2023:** (1)(a) repealed and (2), (3)(a), (3)(c), (4)(a)(V), IP(7), and (8) amended, (HB 23-1224), ch. 159, p. 690, § 4, effective May 10.

10-16-1307. Advisory board - members - rules. (1) (a) The commissioner shall consult with an advisory board to implement this part 13. The governor shall appoint the members of the advisory board on or before July 1, 2022, and shall ensure that the membership of the advisory board has demonstrated experience and expertise in most of the areas listed in subsection (2) of this section.

(b) To the extent possible, the governor shall appoint advisory board members who are diverse with regard to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, and geography. In considering the racial and ethnic diversity of the advisory board, the governor shall attempt to ensure that at least one-third of the members are people of color. In considering the geographic diversity of the advisory board, the governor shall attempt to appoint members from both rural and urban areas of the state.

(2) The governor may appoint up to eleven members to the advisory board and, to the extent practicable, shall include individuals who:

(a) Have faced barriers to health access, including people of color, immigrants, and Coloradans with low incomes;

(b) Have experience purchasing the standardized plan;

(c) Represent consumer advocacy organizations;

(d) Have expertise in health equity;

(e) Have expertise in health benefits for small businesses;

(f) Represent carriers or who have experience with designing a health insurance plan and setting rates;

(g) Represent hospitals or who have experience with contracts between hospitals and carriers;

(h) Represent health-care providers or who have experience with contracts between health-care providers and carriers;

(i) Represent an employee organization that represents employees in the health-care industry; or

(j) Are licensed or retired physicians practicing or who practiced in this state.

(3) The members serve at the pleasure of the governor.

(4) In addition to consulting with the commissioner pursuant to subsection (1)(a) of this section, the advisory board may:

(a) Consider recommendations to streamline prior authorization and utilization management processes for the standardized plan;

(b) Recommend ways to keep health-care services in the communities where patients live; and

(c) Consider whether alternative payment models may be appropriate for particular services, taking into consideration the impacts of such models on health outcomes for people of color.

(5) The division shall provide technical and administrative support to assist the advisory board.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1289, § 1, effective June 16.

10-16-1308. Federal waiver - commissioner application - use of money. (1) On or after June 16, 2021, the commissioner may apply to the secretary of the United States department of health and human services for a state innovation waiver to waive one or more requirements of the federal act as authorized by section 1332 of the federal act to capture all applicable savings to the federal government as a result of the implementation of this part 13.

(2) (a) Upon approval of the 1332 waiver application, the commissioner may use any federal money received through the waiver for the implementation of this part 13 or for the Colorado health insurance affordability enterprise created in section 10-16-1204. The commissioner may allocate federal money to the health insurance affordability cash fund created in section 10-16-1206 for the purposes described in section 10-16-1205 (1)(b) for use by the Colorado health insurance affordability enterprise to increase the value, affordability, quality, and equity of health-care coverage for all Coloradans, with a focus on increasing the value, affordability, quality, and equity of health-care coverage for Coloradans historically and systemically disadvantaged by health and economic systems.

(b) The implementation and operation of section 10-16-1305 (2) is contingent on the approval of the 1332 waiver application and the receipt of federal funds.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1291, § 1, effective June 16.

10-16-1309. Standardized plan - cost shift. (1) If the administrator of a self-funded health insurance plan voluntarily provides to the commissioner its contracted rates and any other information deemed necessary and agreed upon by the administrator and the commissioner, the commissioner may evaluate whether the rates of the self-funded health insurance plan reflect a cost shift between the self-funded plan and the standardized plan offered by a carrier pursuant to section 10-16-1305.

(2) If the commissioner determines there is a cost shift, the commissioner shall, to the extent practicable, provide a description of which categories of services have experienced the greatest cost shift to the administrator of the self-funded health insurance plan.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1291, § 1, effective June 16.

10-16-1310. Reports required - repeal. (1) (a) The commissioner shall contract with an independent third-party organization to prepare three separate reports as specified in subsection (1)(d) of this section, to the extent that information is available regarding the implementation of this part 13 as it relates to the staffing, wages, benefits, training, and working conditions of hospital workers.

(b) In choosing an independent third-party contractor, the commissioner shall consider organizations with experience conducting in-person interviews with health-care employers and employees in Colorado.

(c) The independent third-party contractor may make policy recommendations related to information in the reports and may include data collected from employers, employees, and other third-party sources.

(d) The independent third-party contractor shall deliver the reports to the commissioner as follows:

(I) The first report by July 1, 2023;

(II) The second report by July 1, 2024; and

(III) The third report by July 1, 2025.

(2) The commissioner shall monitor whether there are an adequate number of health-care providers in the carriers' standardized plan network and the percentage of premiums attributable to health-care providers in the network. As part of the rate and form filing required pursuant to section 10-16-107, each carrier shall provide to the commissioner information on whether there are an adequate number of health-care providers in the carrier's standardized plan network and the reduction in premiums as a result of health-care provider participation in the network.

(3) (a) The commissioner shall contract with an independent third-party organization to evaluate how to phase in, to the extent practicable, to a hospital's reimbursement rate methodology described in section 10-16-1306:

(I) A quality metric adjustment; and

(II) An acuity adjustment as measured by a hospital's case-mix index.

(b) The evaluation must be completed by December 31, 2022.

(4) This section is repealed, effective July 1, 2026.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1291, § 1, effective June 16.

10-16-1311. State measurement for accountable, responsive, and transparent (SMART) government act report. (1) The commissioner shall report during the hearings conducted pursuant to the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2:

(a) Beginning in January 2022 and each year thereafter, on the progress of the implementation and operation of this part 13, including the information collected pursuant to section 10-16-1310 (2);

(b) Beginning in January 2024, and each year thereafter, on the carriers' efforts to develop networks that are diverse and culturally responsive pursuant to section 10-16-1304 (1)(g) and the carriers' efforts required by section 10-16-1304 (2); and

(c) In January 2024, January 2025, and January 2026, on the results of the reports required in section 10-16-1310.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1292, § 1, effective June 16.

10-16-1312. Rules. The commissioner may promulgate rules as necessary to develop, implement, and operate this part 13, including rules necessary to align state law with any federal program requirements and applicable rules.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1293, § 1, effective June 16.

10-16-1313. Severability. If any provision of this part 13 or application thereof to any person or circumstances is judged invalid, the invalidity does not affect provisions or applications of this part 13 that can be given effect without the invalid provision or application, and to this end the provisions of this part 13 are declared severable.

Source: L. 2021: Entire part added, (HB 21-1232), ch. 241, p. 1293, § 1, effective June 16.

PART 14

COLORADO PRESCRIPTION DRUG AFFORDABILITY REVIEW BOARD

Cross references: For the legislative declaration in SB 21-175, see section 1 of chapter 240, Session Laws of Colorado 2021.

10-16-1401. Definitions. As used in this part 14, unless the context otherwise requires:

(1) "Advisory council" means the Colorado prescription drug affordability advisory council created in section 10-16-1409.

(2) "Affordability review" means an affordability review of a prescription drug performed by the board pursuant to section 10-16-1406.

(3) "All-payer health claims database" means the all-payer health claims database described in section 25.5-1-204.

(4) "Authorized generic drug" has the meaning set forth in 42 CFR 447.502.

(5) "Biological product" has the meaning set forth in 42 U.S.C. sec. 262 (i)(1).

(6) "Biosimilar drug" means a prescription drug that is produced or distributed in accordance with a biological product license issued pursuant to 42 U.S.C. sec. 262 (k)(3).

(7) "Board" means the Colorado prescription drug affordability review board created in section 10-16-1402.

(7.5) "Board activity" means:

(a) Selecting prescription drugs for an affordability review pursuant to section 10-16-1406 (2);

(b) Determining whether a prescription drug is unaffordable pursuant to section 10-16-1406 (3);

(c) Selecting prescription drugs for which the board establishes an upper payment limit pursuant to section 10-16-1407; and

(d) Establishing an upper payment limit for a prescription drug pursuant to section 10-16-1407.

(8) "Brand-name drug" means a prescription drug that is produced or distributed in accordance with an original new drug application approved pursuant to 21 U.S.C. sec. 355. "Brand-name drug" does not include an authorized generic drug.

(9) "Carrier" has the meaning set forth in section 10-16-102 (8).

(10) "Conflict of interest" means an association, including a financial or personal association, that has the potential to bias or appear to bias an individual's decisions in matters related to the board or the advisory council or the conduct of the activities of the board or the advisory council. "Conflict of interest" includes any instance in which a board member; an advisory council member; a staff member; a contractor of the division, on behalf of the board; or an immediate family member of a board member, an advisory council member, a staff member, or a contractor of the division, on behalf of the board, has received or could receive:

(a) A financial benefit of any amount derived from the results or findings of a study or determination that is reached by or for the board; or

(b) A financial benefit from an individual or company that owns or manufactures a prescription drug, service, or item that is being or will be studied by the board.

(11) "Financial benefit" means honoraria, fees, stock, or any other form of compensation, including increases to the value of existing stock holdings.

(12) "Generic drug" means:

(a) A prescription drug that is marketed or distributed in accordance with an abbreviated new drug application approved pursuant to 21 U.S.C. sec. 355 (j);

(b) An authorized generic drug; or

(c) A prescription drug that was introduced for retail sale before 1962 that was not originally marketed under a new drug application.

(13) "Health benefit plan" has the meaning set forth in section 10-16-102 (32).

(14) "Inflation" means the annual percentage change in the United States department of labor's bureau of labor statistics consumer price index for Denver-Aurora-Lakewood for all items paid by all urban consumers, or its applicable predecessor or successor index.

(15) (a) **[*Editor's note: This version of the introductory portion to subsection (15)(a) is effective until January 1, 2026.*]** "Large employer" means any person, firm, corporation, partnership, or association that:

(15) (a) **[*Editor's note: This version of the introductory portion to subsection (15)(a) is effective January 1, 2026.*]** "Large employer" means any person that:

(I) Is actively engaged in business;

(II) **[*Editor's note: This version of subsection (15)(a)(II) is effective until January 1, 2026.*]** Employed an average of more than one hundred eligible employees on business days during the immediately preceding calendar year, except as provided in subsection (15)(c) of this section; and

(II) **[*Editor's note: This version of subsection (15)(a)(II) is effective January 1, 2026.*]** Employed an average of more than fifty eligible employees on business days during the immediately preceding calendar year, except as provided in subsection (15)(c) of this section; and

(III) Was not formed primarily for the purpose of purchasing insurance.

(b) For purposes of determining whether an employer is a "large employer", the number of eligible employees is calculated using the method set forth in 26 U.S.C. sec. 4980H (c)(2)(E).

(c) In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether the employer is a large employer is based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(16) "Manufacturer" means a person that:

(a) Engages in the manufacture of a prescription drug that is sold to purchasers located in this state; or

(b) (I) Enters into a lease or other contractual agreement with a manufacturer to market and distribute a prescription drug in this state under the person's own name; and

(II) Sets or changes the wholesale acquisition cost of the prescription drug in this state.

(17) "Optional participating plan" means a self-funded health benefit plan offered in Colorado that elects to subject its purchases of or payer reimbursements for prescription drugs for its members in Colorado to the requirements of this part 14, as described in section 10-16-1407 (8).

(18) "Practitioner" has the meaning set forth in section 12-280-103 (40).

(19) "Prescription drug" has the meaning set forth in section 12-280-103 (42); except that the term includes only prescription drugs that are intended for human use.

(20) "Pricing information" means information about the price of a prescription drug, including information that explains or helps explain how the price was determined.

(21) "Small employer" has the meaning set forth in section 10-16-102 (61).

(22) "State entity" means any agency of state government that purchases or reimburses payers for prescription drugs on behalf of the state for a person whose heath care is paid for by the state, including any agent, vendor, contractor, or other party acting on behalf of the state.

(23) "Upper payment limit" means the maximum amount that may be paid or billed for a prescription drug that is dispensed or distributed in Colorado in any financial transaction concerning the purchase of or reimbursement for the prescription drug.

(24) "Wholesale acquisition cost" has the meaning set forth in 42 U.S.C. sec. 1395w-3a (c)(6)(B).

(25) "Wholesaler" has the meaning set forth in section 12-280-103 (55).

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1257, § 2, effective June 16. **L. 2023:** (7.5) added, (HB 23-1225), ch. 162, p. 704, § 1, effective August 7. **L. 2024:** IP(15)(a) and (15)(a)(II) amended, (SB 24-073), ch. 146, p. 592, § 4, effective January 1, 2026.

Editor's note: Subsection (15) is repealed when the conditions under § 10-16-105.1 (3.5)(e)(II) have occured.

10-16-1402. Colorado prescription drug affordability review board - created - membership - terms - conflicts of interest. (1) The Colorado prescription drug affordability review board is created in the division. The board is a **type 1** entity, as defined in section 24-1-105. The board exercises its powers and performs its duties and functions under the department of regulatory agencies and is allocated to the division of insurance. The board is a body politic

and corporate and is an instrumentality of the state. The board is an independent unit of state government, and the exercise by the board of its authority under this part 14 is an essential public function.

(2) (a) The board consists of five members, who must each have an advanced degree and experience or expertise in health-care economics or clinical medicine.

(b) The governor shall appoint each board member, subject to confirmation by the senate. All of the initial members of the board must be appointed by October 1, 2021.

(c) The term of office of each board member is three years; except that, as to the terms of the members who are first appointed to the board, two such members shall serve three-year initial terms, two such members shall serve two-year initial terms, and one such member shall serve a one-year initial term, to be determined by the governor. The governor may remove any appointed member of the board for malfeasance in office, for failure to regularly attend meetings, or for any cause that renders the member incapable or unfit to discharge the duties of the member's office, and any such removal is not subject to review.

(d) The governor shall designate one member of the board to serve as the chair. A majority of the board constitutes a quorum. The concurrence of a majority of the board in any matter within its powers and duties is required for any determination made by the board.

(3) (a) An individual who is being considered for appointment to the board shall disclose any conflict of interest to the individual's potential appointing authority. When appointing a member of the board, an appointing authority shall consider any conflict of interest disclosed by the prospective member.

(b) A board member must not be an employee, board member, or consultant of:

(I) A manufacturer or a trade association of manufacturers;

(II) A carrier or a trade association of carriers; or

(III) A pharmacy benefit manager or a trade association of pharmacy benefit managers.

(c) (I) Board members shall recuse themselves from any board activity or vote in any case in which they have a conflict of interest.

(II) Staff members and contractors of the division, on behalf of the board, shall disclose any conflict of interest related to a prescription drug for which the board is conducting an affordability review or establishing an upper payment limit.

(III) Notwithstanding subsection (3)(d) of this section and the reporting requirements set forth in section 10-16-1414 (1)(f), a conflict of interest disclosed by a staff member or by a contractor of the division, which disclosure pertains to a personal association, must remain confidential. The board, upon review of such a disclosure, may direct the staff member or contractor to recuse themselves based on the conflict of interest.

(d) On and after January 1, 2022, the division shall maintain a page on its public website for the board to use for its purposes. The board shall disclose on the page each conflict of interest that is disclosed to the board pursuant to subsection (3)(c) of this section and section 10-16-1409 (5)(b).

(e) Board members, staff members, contractors of the division, on behalf of the board, and immediate family members of board members, staff members, or contractors shall not accept a financial benefit or gifts, bequests, or donations of services or property that suggest a conflict of interest or have the appearance of creating bias in the work of the board.

(4) The attorney general shall assign an assistant attorney general to provide legal counsel to the board. Any assistant attorney general assigned to the board pursuant to this subsection (4) shall disclose any conflict of interest to the board.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1260, § 2, effective June 16. **L. 2022:** (1) amended, (SB 22-162), ch. 469, p. 3390, § 102, effective August 10. **L. 2023:** (3)(c) amended, (HB 23-1225), ch. 162, p. 705, § 2, effective August 7.

Cross references: For the short title (the "Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 22-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

10-16-1403. Colorado prescription drug affordability review board - powers and duties - rules. (1) To protect Colorado consumers from excessive prescription drug costs, the board shall:

(a) Collect and evaluate information concerning the cost of prescription drugs sold to Colorado consumers, as described in section 10-16-1405;

(b) Perform affordability reviews of prescription drugs, as described in section 10-16-1406;

(c) Establish upper payment limits for prescription drugs, as described in section 10-16-1407; and

(d) Make policy recommendations to the general assembly to improve the affordability of prescription drugs for Colorado consumers, as described in section 10-16-1414 (1)(h).

(2) The board may establish ad hoc work groups to consider matters related to the work of the board pursuant to this part 14. Ad hoc work groups may include members of the public.

(3) The division, on behalf of the board, may enter into a contract with a qualified, independent third party for any service necessary to carry out the powers and duties of the board. A third party with which the division contracts pursuant to this subsection (3), including any of the third party's directors, officers, employees, contractors, or agents, shall not release or publish any information that the third party acquires pursuant to its performance under the contract. Any third party with which the division contracts pursuant to this subsection (3) shall disclose any conflict of interest to the board.

(4) In carrying out its duties pursuant to this part 14, the division, when performing its duties on behalf of the board, is exempt from the state "Procurement Code", articles 101 to 112 of title 24.

(5) The board shall promulgate rules as necessary, pursuant to article 4 of title 24, for the implementation of this part 14.

(6) (a) The division, on behalf of the board, may seek, accept, and expend gifts, grants, and donations from private or public sources for the purposes of this part 14, and any such gifts, grants, and donations are continuously appropriated to the department of regulatory agencies; except that the division shall not accept any gift, grant, or donation that creates a conflict of interest or the appearance of any conflict of interest for any board member.

(b) The general assembly finds that the implementation of this part 14 does not rely entirely on the receipt of adequate funding through gifts, grants, or donations. Therefore, the board is not subject to the reporting requirements described in section 24-75-1303.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1261, § 2, effective June 16.

10-16-1404. Colorado prescription drug affordability review board meetings - required to be public - exceptions. (1) The board shall hold its first meeting within six weeks after all of the board members are appointed and shall meet at least every six weeks thereafter to review prescription drugs; except that the chair may cancel or postpone a meeting if the board has no prescription drugs to review or for good cause.

(2) The board is a state public body for purposes of section 24-6-402, and the board's meetings and the meetings of ad hoc work groups of the board are public meetings.

(3) The board shall meet in executive session to discuss proprietary information. The board and any board members, officers, directors, employees, contractors, and agents shall not disclose or otherwise make available to the public any materials or information containing trade-secret, confidential, or proprietary data that is not otherwise available to the public. Electronic recordings of such executive sessions are not permitted if they would result in the disclosure of any materials or information containing trade-secret, confidential, or proprietary data, and in no case shall minutes from such executive sessions disclose or include materials or information containing trade-secret, confidential, or proprietary data. The board shall not take any of the following actions while meeting in executive session:

(a) Deliberations concerning whether to subject a prescription drug to an affordability review as described in section 10-16-1406;

(b) Votes concerning whether to establish an upper payment limit on a prescription drug; or

(c) Any final decision of the board.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1262, § 2, effective June 16. **L. 2023:** (1) amended, (HB 23-1225), ch. 162, p. 705, § 3, effective August 7.

10-16-1405. Colorado prescription drug affordability review board - reports from carriers and pharmacy benefit management firms required - confidential materials. (1) Beginning in the 2022 calendar year, for all prescription drugs dispensed at a pharmacy in this state and paid for by a carrier pursuant to a health benefit plan issued under part 2, 3, or 4 of this article 16 during the immediately preceding calendar year, including brand-name drugs, authorized generic drugs, biological products, and biosimilar drugs:

(a) Each carrier and each pharmacy benefit management firm acting on behalf of a carrier shall report to the all-payer health claims database the following information:

(I) The top fifteen prescription drugs by volume, calculated by unit, for which the carrier paid;

(II) The fifteen costliest prescription drugs for which the carrier paid, as determined by total annual plan spending;

(III) The fifteen prescription drugs paid for by the carrier that accounted for the highest increase in total annual plan spending when compared with the total annual plan spending for the same prescription drugs in the year immediately preceding the year for which the information is reported;

(IV) The fifteen prescription drugs that caused the greatest increases in the carrier's premiums;

(V) The fifteen prescription drugs for which the carrier paid most frequently and for which the carrier received a rebate from manufacturers;

(VI) The fifteen prescription drugs for which the carrier received the highest rebates, as determined by percentages of the price of the prescription drug;

(VII) The fifteen prescription drugs for which the carrier received the largest rebates;

(VIII) The total spending for each of the following categories of prescription drugs:

(A) Brand-name drugs purchased from retail pharmacies;

(B) Authorized generic drugs purchased from retail pharmacies;

(C) Brand-name drugs purchased from mail-order pharmacies;

(D) Authorized generic drugs purchased from mail-order pharmacies;

(E) Prescription drugs dispensed by a practitioner in accordance with section 12-280-120 (6);

(F) Prescription drugs administered in an inpatient hospital setting; and

(G) Prescription drugs administered in an outpatient hospital setting; and

(IX) The total spending for the prescription drugs described in subsection (1)(a)(VIII) of this section paid for by a carrier pursuant to a health benefit plan issued under part 2, 3, or 4 of this article 16 during the immediately preceding calendar year for each of the following market sectors:

(A) Individual;

(B) Small employer; and

(C) Large employer.

(b) If the all-payer health claims database does not collect and maintain the data that is required to be reported to the database pursuant to subsection (1)(a) of this section, the administrator of the all-payer health claims database shall amend the requirements regarding the data to be submitted to the database pursuant to section 25.5-1-204 (5) to include the data required by subsection (1)(a) of this section during the next update of such requirements, but no later than June 1, 2022.

(2) The administrator of the all-payer health claims database shall provide to the commissioner, in a form and manner determined by the commissioner, the information that is reported to the database by carriers and pharmacy benefit management firms pursuant to subsection (1)(a) of this section.

(3) (a) Except as provided in subsection (3)(b) of this section, the commissioner shall:

(I) Post the information reported by carriers and pharmacy benefit management firms pursuant to this section on the division's website; and

(II) Provide the information reported by carriers and pharmacy benefit management firms pursuant to this section to the board, in a form and manner prescribed by the board.

(b) If a carrier or pharmacy benefit management firm claims that information submitted pursuant to this section is confidential or proprietary, the commissioner shall review the information and redact specific items that the carrier or pharmacy benefit management firm demonstrates to be confidential or proprietary. The commissioner shall not disclose redacted items to any person; except that the commissioner may disclose redacted items:

(I) As may be required pursuant to the "Colorado Open Records Act", part 2 of article 72 of title 24; and

(II) To employees of the division, as necessary.

(4) The requirement in this section to report information relating to the cost of prescription drugs is intended to create transparency in prescription drug pricing and does not:

(a) Prohibit a manufacturer of a prescription drug from making pricing decisions about its prescription drugs; or

(b) Prohibit purchasers, both public and private, or pharmacy benefit management firms from negotiating discounts and rebates consistent with existing state and federal law.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1263, § 2, effective June 16.

10-16-1406. Colorado prescription drug affordability review board - affordability reviews of prescription drugs. (1) The board may conduct affordability reviews of prescription drugs in accordance with this section. The board shall identify, for purposes of determining whether to conduct an affordability review:

(a) Any prescription drug that has:

(I) A wholesale acquisition cost of three thousand dollars or more;

(I.5) An increase of three hundred dollars or more above the wholesale acquisition cost for the prescription drug in the preceding twelve months;

(II) An increase of two hundred percent or more above the wholesale acquisition cost for the prescription drug in the preceding twelve months; or

(III) A current wholesale acquisition cost for an average course of treatment per person per year of thirty thousand dollars or more; and

(b) Any biosimilar drug that has an initial wholesale acquisition cost that is not at least fifteen percent lower than the wholesale acquisition cost of the corresponding biological product.

(c) Repealed.

(1.1) Repealed.

(2) After identifying prescription drugs as described in subsection (1) of this section, the board shall determine whether to conduct an affordability review for an identified prescription drug by:

(a) Evaluating the class of the prescription drug and whether any therapeutically equivalent prescription drugs are available for sale;

(b) Evaluating aggregated data;

(c) Seeking and considering input from the advisory council about the prescription drug;

(d) Considering the average patient's out-of-pocket cost for the prescription drug; and

(e) Considering whether the drug has an approved orphan drug designation for one or more rare diseases and no other indications and, if so, considering input from consumers and the Colorado rare disease advisory council created in section 25-1-1503.

(3) If the board conducts an affordability review of a prescription drug, the affordability review must determine whether use of the prescription drug consistent with the labeling approved for the prescription drug by the FDA or with standard medical practice is unaffordable for Colorado consumers.

(4) In performing an affordability review, to the extent practicable, the board shall consider:

(a) The wholesale acquisition cost of the prescription drug;

(b) The cost and availability of therapeutic alternatives to the prescription drug in the state;

(c) The effect of the price on Colorado consumers' access to the prescription drug;

(d) The relative financial effects on health, medical, or social services costs, as the effects can be quantified and compared to baseline effects of existing therapeutic alternatives to the prescription drug;

(e) The patient copayment or other cost sharing that is associated with the prescription drug and typically required pursuant to health benefit plans issued by carriers in the state;

(f) The impact on safety net providers if the prescription drug is available through section 340B of the federal "Public Health Service Act", Pub.L. 78-410;

(g) Orphan drug status;

(h) Input from:

(I) Patients and caregivers affected by the condition or disease that is treated by the prescription drug that is under review by the board;

(II) Individuals who possess scientific or medical training with respect to a condition or disease treated by the prescription drug that is under review by the board; and

(III) The Colorado rare disease advisory council created in section 25-1-1503;

(i) Any other information that a manufacturer, carrier, pharmacy benefit management firm, or other entity chooses to provide; and

(j) Any other factors as determined by rules promulgated by the board pursuant to section 10-16-1403 (5).

(5) Trade-secret, confidential, or proprietary information obtained by the board pursuant to this section may be accessed only by board members and staff or by a qualified independent third party that has contracted with the division pursuant to section 10-16-1403 (3) and is subject to a nondisclosure agreement prohibiting disclosure of such information. Any person with access to such information shall protect the information from direct or indirect publication or release to any person.

(6) In performing an affordability review of a prescription drug, the board may consider any documents and information relating to the manufacturer's selection of the introductory price or price increase of the prescription drug, including documents and information relating to:

(a) Life-cycle management;

(b) The average cost of the prescription drug in the state;

(c) Market competition and context;

(d) Projected revenue;

(e) The estimated cost-effectiveness of the prescription drug; and

(f) Off-label usage of the prescription drug.

(7) (a) To the extent practicable, the board may access pricing information for prescription drugs by:

(I) Accessing publicly available pricing information from a state to which manufacturers report pricing information;

(II) Accessing available pricing information from the all-payer health claims database and from state entities; and

(III) Accessing information that is available from other countries.

(b) To the extent that there is no publicly available information with which to conduct an affordability review, the board may request that a manufacturer, carrier, or pharmacy benefit management firm provide pricing information for any prescription drug identified pursuant to subsection (1) of this section. The failure of an entity to provide pricing information to the board

for an affordability review does not affect the authority of the board to conduct the affordability review, as described in this section.

(8) The board shall issue a report summarizing, to the extent permitted by section 10-16-1404 (3), the data that the board considered in making the board's determination as to whether a prescription drug is unaffordable. The board shall make the report available on its public web page.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1265, § 2, effective June 16. **L. 2023:** IP(1), (1)(a), (1)(b), and IP(2) amended and (8) added, (HB 23-1225), ch. 162, p. 705, § 4, effective January 1, 2025; (1.1) added by revision, (HB 23-1225), ch. 162, pp. 705, 709, §§ 4, 11. **L. 2024:** (2)(c), (2)(d), and (4)(h) amended and (2)(e) added, (SB 24-203), ch. 454, p. 3150, § 1, effective August 7.

Editor's note: (1) Section 97 of HB 23-1301 amended the effective date of HB 23-1225 from January 1, 2026, to January 1, 2025. (See L. 2023, p. 1848.)

(2) Subsection (1.1) provided for the repeal of subsections (1)(c) and (1.1), effective January 1, 2025. (See L. 2023, pp. 705, 709.)

10-16-1407. Colorado prescription drug affordability review board - upper payment limits for certain prescription drugs - rules - severability. (1) (a) The board may establish an upper payment limit for any prescription drug for which the board has performed an affordability review pursuant to section 10-16-1406 and determined that the use of the prescription drug is unaffordable for Colorado consumers; except that:

(I) The board may not establish an upper payment limit for more than twelve prescription drugs in each calendar year for three years beginning April 1, 2022, unless the board determines that there is a need to establish upper payment limits for more than twelve prescription drugs, in which case the board may establish an upper payment limit for up to eighteen prescription drugs so long as the board has sufficient staff support to do so; and

(II) For each prescription drug for which the board establishes an upper payment limit, the board may include multiple national drug codes, as described in 21 CFR 207.33, that are indicated for the prescription drug.

(b) The failure of an entity to provide information to the board pursuant to section 10-16-1406 (7)(b) does not affect the authority of the board to establish an upper payment limit for a prescription drug.

(2) The board shall determine by rule the methodology for establishing an upper payment limit for a prescription drug to protect consumers from the excessive cost of prescription drugs and ensure they can access prescription drugs necessary for their health. The methodology must include consideration of:

(a) The cost of administering or dispensing the prescription drug;

(b) The cost of distributing the prescription drug to consumers in the state;

(c) The status of the prescription drug on the drug shortage list published by the drug shortage program within the FDA; and

(d) Other relevant costs related to the prescription drug.

(3) The methodology determined by the board pursuant to subsection (2) of this section must consider the impact to older adults and persons with disabilities and shall not place a lower value on their lives.

(4) The methodology determined by the board pursuant to subsection (2) of this section:

(a) Shall not consider research or methods that employ a dollars-per-quality adjusted life year, or similar measure, that discounts the value of a life because of an individual's disability or age; and

(b) Must authorize a pharmacy licensed by the state board of pharmacy to charge reasonable fees, to be paid by the providing health benefit plan of the consumer, for dispensing or delivering a prescription drug for which the board has established an upper payment limit.

(5) An upper payment limit applies to all purchases of and payer reimbursements for a prescription drug that is dispensed or administered to individuals in the state in person, by mail, or by other means and for which an upper payment limit is established. The board shall promulgate rules that establish upper payment limits and the effective date of any upper payment limit established by the board, which effective date is at least six months after the adoption of the upper payment limit by the board and applies only to purchases, contracts, and plans that are issued on or renewed after the effective date.

(6) The board shall promulgate rules to notify consumers of any decision to establish an upper payment limit pursuant to this section.

(7) Any information submitted to the board in accordance with this section or section 10-16-1405 or 10-16-1406 is subject to public inspection only to the extent allowed under the "Colorado Open Records Act", part 2 of article 72 of title 24, and in no case shall trade-secret, confidential, or proprietary information be disclosed to any person who is not authorized to access such information pursuant to section 10-16-1406.

(8) Notwithstanding any provision of this part 14 to the contrary, with respect to an entity providing or administering a self-funded health benefit plan and its plan members, the requirements of this part 14 apply only if the plan elects to be subject to this part 14 for its members in Colorado. Such a plan is an optional participating plan for the purposes of this part 14.

(9) If any provision of this section or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section that can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

(10) For any upper payment limit established by the board pursuant to this section, the board shall:

(a) Inquire of manufacturers of the prescription drug as to whether each such manufacturer is able to make the prescription drug available for sale in the state and request the rationale for the manufacturer's response; and

(b) Submit annually to the health and human services committee of the senate and the health and insurance committee of the house of representatives, or to any successor committees, the response of each manufacturer to the inquiry described in subsection (10)(a) of this section.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1268, § 2, effective June 16. **L. 2023:** (1) and (5) amended, (HB 23-1225), ch. 162, p. 706, § 5, effective August 7.

10-16-1408. Colorado prescription drug affordability review board - judicial review. (1) The following board functions are not final agency actions subject to judicial review under the "State Administrative Procedure Act", article 4 of title 24:

(a) Identification of eligible prescription drugs pursuant to section 10-16-1406 (1);

(b) Selection of a prescription drug pursuant to section 10-16-1406 (2); and

(c) Determination that a prescription drug is unaffordable pursuant to section 10-16-1406 (3).

(2) A rule of the board establishing an upper payment limit is a final agency action subject to judicial review under the "State Administrative Procedure Act", article 4 of title 24. A party seeking judicial review of a rule establishing an upper payment limit may seek review of whether the prescription drug satisfies the necessary criteria in section 10-16-1406 to be eligible for an upper payment limit.

(3) Repealed.

(4) Notwithstanding any provision of law to the contrary:

(a) An individual may request an expedited review, as described in section 10-16-113.5, of access to a prescription drug that is unavailable to the individual because a manufacturer refuses to make the drug available as a result of an upper payment limit established for the prescription drug by the board; and

(b) A carrier may disregard the upper payment limit if the independent external review entity that performs the expedited review determines pursuant to such review that the prescription drug should be covered for and available to that individual.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1270, § 2, effective June 16. **L. 2023:** (1) and (2) amended and (3) repealed, (HB 23-1225), ch. 162, p. 707, § 6, effective August 7.

10-16-1409. Colorado prescription drug affordability advisory council - created - membership - powers and duties. (1) (a) The Colorado prescription drug affordability advisory council is created in the division to provide stakeholder input to the board regarding the affordability of prescription drugs. The advisory council is a **type 2** entity, as defined in section 24-1-105. The advisory council exercises its powers and performs its duties and functions under the department of regulatory agencies and is allocated to the division of insurance. The advisory council includes fifteen members as follows:

(I) The executive director of the department of health care policy and financing or the executive director's designee; and

(II) Fourteen members appointed by the board as follows:

(A) Two members who are health-care consumers or who represent health-care consumers;

(B) One member representing a statewide health-care consumer advocacy organization;

(C) One member representing health-care consumers who are living with chronic diseases;

(D) One member representing a labor union;

(E) One member representing employers;

(F) One member representing carriers;

(G) One member representing pharmacy benefit management firms;

(H) One member representing health-care professionals with prescribing authority;

(I) One member who is employed by an organization that performs research concerning prescription drugs, including research concerning pricing information;

(J) One member representing manufacturers of brand-name drugs;

(K) One member representing manufacturers of generic drugs;

(L) One member representing pharmacists; and

(M) One member representing wholesalers.

(b) To the extent possible, the board shall appoint council members who have experience serving underserved communities and reflect the diversity of the state with regard to race, ethnicity, immigration status, income, wealth, disability, age, gender identity, and geography. In considering geographic diversity, the board shall ensure at least one council member resides on the eastern plains and one member resides on the western slope, and the board shall attempt to appoint members from each congressional district in the state.

(c) All of the initial members of the advisory council must be appointed by January 1, 2022.

(2) Each member of the advisory council must possess knowledge of at least one of the following subject matters:

(a) The pharmaceutical business model;

(b) Supply chain business models;

(c) The practice of medicine or clinical training;

(d) Health-care consumer or patient perspectives;

(e) Health-care cost trends and drivers;

(f) Clinical and health services research; or

(g) The state's health-care marketplace.

(3) The term of each member of the advisory council is three years; except that the members initially appointed to the advisory council pursuant to subsections (1)(a)(II)(A) to (1)(a)(II)(E) of this section shall each serve initial terms of two years.

(4) The chair of the board shall designate one member of the advisory council to serve as chair of the advisory council.

(5) (a) An individual who is being considered for appointment to the advisory council shall disclose any conflict of interest to the board in a form and manner prescribed by the board. When appointing a member of the advisory council, the board shall consider any conflict of interest disclosed by the prospective member.

(b) The chair of the advisory council shall report to the board any conflict of interest that is disclosed to the advisory council. The board shall include information concerning such disclosures on its public website pursuant to section 10-16-1402 (3)(d).

(6) The advisory council shall meet at least once every three months; except that the chair may cancel or postpone a meeting.

(7) (a) Except as described in subsection (7)(b) of this section, the advisory council shall conduct all of its meetings in public.

(b) Notwithstanding section 24-6-402, the advisory council may meet privately in groups of three or fewer members for the following purposes, so long as no formal action is taken at the meeting:

(I) To gather and understand data; or

(II) To establish, organize, and plan for the business of the advisory council.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1271, § 2, effective June 16. **L. 2022:** IP(1)(a) amended, (SB 22-162), ch. 469, p. 3390, § 103, effective August 10.

Cross references: For the short title (the "Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 22-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

10-16-1410. Use of savings - report - rules. (1) Any savings generated for a health benefit plan that are attributable to the establishment of an upper payment limit established by the board pursuant to section 10-16-1407 must be used by the carrier that issues the health benefit plan to reduce costs to consumers, prioritizing the reduction of out-of-pocket costs for prescription drugs.

(2) On or before March 15, 2023, and on or before March 15 each year thereafter, each state entity and each carrier that issues a health benefit plan or optional participating plan shall submit to the board a report describing the savings achieved during the preceding plan year for each prescription drug for which the board established an upper payment limit during the preceding year and how those savings were used to satisfy the requirement described in subsection (1) of this section.

(3) On or before November 1, 2022, the board shall promulgate rules establishing a formula for calculating savings for the purpose of complying with subsection (1) of this section.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1273, § 2, effective June 16.

10-16-1411. Unlawful acts - enforcement - penalties. (1) On and after January 1, 2022, it is unlawful for any person to purchase or reimburse a payer for a prescription drug for which the board has established an upper payment limit pursuant to section 10-16-1407 at an amount that exceeds the upper payment limit established by the board for that prescription drug, regardless of whether the prescription drug is dispensed or distributed in person, by mail, or by other means.

(2) On and after January 1, 2023, each state entity, carrier, and optional participating plan shall require compliance with an upper payment limit established by the board.

(3) The attorney general is authorized to enforce this part 14 on behalf of any state entity or any consumer of prescription drugs.

(4) Notwithstanding any provision of this part 14 to the contrary, as used in this section, "person" does not include an individual who acquires a prescription drug for the individual's own use or for a family member's use.

(5) Notwithstanding any provision of this section to the contrary, a carrier or state agency that is required pursuant to state or federal law to purchase or reimburse a payer for a prescription drug for which the board has established an upper payment limit pursuant to section 10-16-1407 is not subject to an enforcement action for a violation of subsection (1) or (2) of this section for that particular prescription drug.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1273, § 2, effective June 16.

10-16-1412. Notice of withdrawal of prescription drugs with upper payment limits required - rules - penalty. (1) Any manufacturer that intends to withdraw from sale or distribution within the state a prescription drug for which the board has established an upper payment limit pursuant to section 10-16-1407 shall provide a notice of withdrawal in writing at least one hundred eighty days before the withdrawal to:

(a) The commissioner;

(b) The attorney general; and

(c) Each entity in the state with which the manufacturer has contracted for the sale or distribution of the prescription drug.

(2) The board shall promulgate rules to notify consumers of the intent of any manufacturer to withdraw a prescription drug from sale or distribution within the state, as described in subsection (1) of this section.

(3) After providing notice and a hearing as described in section 24-4-105, the commissioner may require a manufacturer to pay a penalty not to exceed five hundred thousand dollars if the commissioner determines that the manufacturer failed to provide the notice required by subsection (1) of this section before withdrawing from sale or distribution within the state a prescription drug for which the board has established an upper payment limit pursuant to section 10-16-1407.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1274, § 2, effective June 16.

10-16-1413. Optional participating plans - notice of election to participate required. An optional participating plan that elects to subject its purchases of or payer reimbursements for prescription drugs in Colorado to the requirements of this part 14 shall notify the commissioner in writing within thirty days after such election.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1274, § 2, effective June 16.

10-16-1414. Reports. (1) Notwithstanding section 24-1-136 (11)(a), on or before July 1, 2023, and on or before July 1 each year thereafter, the board shall submit a report to the governor, the health and insurance committee of the house of representatives, and the health and human services committee of the senate, or to any successor committees, summarizing the work of the board during the preceding calendar year. At a minimum, the report must include:

(a) Publicly available data concerning price trends for prescription drugs;

(b) The number of prescription drugs that were subjected to an affordability review by the board pursuant to section 10-16-1406, including the results of each affordability review;

(c) A list of each prescription drug for which the board established an upper payment limit pursuant to section 10-16-1407, including the amount of the upper payment limit;

(d) The impact of any upper payment limits established by the board pursuant to section 10-16-1407 on health-care providers, pharmacies, and patients' ability to access any prescription drugs for which the board has established upper payment limits;

(e) A summary of any judicial reviews of board decisions, including an indication of the outcome of any judicial review;

(f) A description of each conflict of interest that was disclosed to the board during the preceding year;

(g) A description of any violations of any of the provisions of this part 14, including an indication of any enforcement action taken in response to any such violation; and

(h) Any recommendations the board may have for the general assembly concerning legislative and regulatory policy changes to increase the affordability of prescription drugs and reduce the effects of excess costs on consumers and commercial health insurance premiums in the state.

(2) The board shall post the report described in subsection (1) of this section on the public web page maintained by the division for the board pursuant to section 10-16-1402 (3)(d).

(3) (a) The chair of the board shall present to the joint health and insurance committee of the house of representatives and health and human services committee of the senate, or any successor committees, which presentation occurs pursuant to the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2, information concerning any prescription drug for which the board established an upper payment limit during the preceding calendar year. The chair shall summarize for the committee members:

(I) The affordability review of the prescription drug, including the results of the board's considerations as described in section 10-16-1406 (4) and, if applicable, section 10-16-1406 (6); and

(II) The establishment of the upper payment limit, including a summary of the methodology used to establish the upper payment limit.

(b) Based on the information presented in subsection (3)(a) of this section, members of the joint health and insurance committee of the house of representatives and health and human services committee of the senate, or any successor committees, may pursue legislation, if the majority of committee members vote to pursue such legislation, to discontinue the upper payment limit for any prescription drug for which the board established an upper payment limit. Any such legislation shall not count against any limitation upon the number of bills that a member of the general assembly may introduce each regular legislative session, which limitation may exist pursuant to rules adopted by the general assembly.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1274, § 2, effective June 16. **L. 2023:** IP(1), (1)(b), and (1)(e) amended, (HB 23-1225), ch. 162, p. 708, § 7, effective August 7.

10-16-1415. Exemption - prescription drugs derived from cannabis. Notwithstanding any provision of this part 14 to the contrary, the board has no authority to perform an affordability review of, or to establish an upper payment limit for, any prescription drug that is derived in whole or in part from cannabis.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1276, § 2, effective June 16.

10-16-1416. Repeal of part. This part 14 is repealed, effective September 1, 2031. Before the repeal, the functions of the board are scheduled for review in accordance with section 24-34-104.

Source: L. 2021: Entire part added, (SB 21-175), ch. 240, p. 1276, § 2, effective June 16. **L. 2023:** Entire section amended, (HB 23-1225), ch. 162, p. 708, § 8, effective August 7.

PART 15

340B PRESCRIPTION DRUG PROGRAM ANTI-DISCRIMINATION ACT

10-16-1501. Short title. The short title of this part 15 is the "Colorado 340B Prescription Drug Program Anti-discrimination Act".

Source: L. 2022: Entire part added, (HB 22-1122), ch. 312, p. 2230, § 1, effective August 10.

10-16-1502. Legislative declaration. (1) The general assembly declares that the purpose of this part 15 is to:

(a) Prohibit a pharmacy benefit manager or carrier from imposing fees, charge backs, or other adjustments on covered entities or contract pharmacies based on their participation in the 340B drug pricing program;

(b) Prohibit a pharmacy benefit manager or carrier from requiring a claim for a drug to include a modifier to indicate that the drug is a 340B drug unless the claim is for payment, directly or indirectly, by the medicaid program; and

(c) Provide for powers and duties of the commissioner and the division.

Source: L. 2022: Entire part added, (HB 22-1122), ch. 312, p. 2230, § 1, effective August 10.

10-16-1503. Definitions. As used in this part 15, unless the context otherwise requires:

(1) "340B covered entity" means a covered entity, as defined in section 340B (a)(4) of the federal "Public Health Service Act", 42 U.S.C. sec. 256b (a)(4), as amended.

(2) "340B drug" means a drug purchased through the 340B drug pricing program by a 340B covered entity.

(3) "340B drug pricing program" or "340B program" means the program described in 42 U.S.C. sec. 256b.

(4) "Contract pharmacy" means a pharmacy operating under contract with a 340B covered entity to provide dispensing services to the 340B covered entity as described in 75 Fed. Reg. 10272 (2010) or any superseding guidance.

(5) (a) "Drug coverage" means coverage or payment for a prescription drug dispensed by a pharmacy to a patient pursuant to:

(I) A health coverage plan;

(II) A managed care organization, as defined in section 25.5-5-403 (5); or

(III) Any other contractual or other legal obligation to provide coverage or payment for a prescription drug dispensed by a pharmacy to a patient.

(b) "Drug coverage" does not include:

(I) Reimbursement for covered outpatient drugs, as that term is defined in section 42 U.S.C. sec. 1396r-8 (k)(2), on a fee-for-service basis under the medicaid program; or

(II) Any amounts paid by an individual on the individual's own behalf or on behalf of another individual without a contractual or legal obligation to do so.

(6) "Medicaid program" means the medical assistance program established pursuant to articles 4 to 6 of title 25.5.

(7) (a) "Third party" means:

(I) A carrier or pharmacy benefit manager that provides or manages drug coverage under a health coverage plan; or

(II) A system of health insurance for state or local government employees, their dependents, and retirees, including a group benefit plan, as defined in section 24-50-603 (9), and a group health-care program designed pursuant to section 24-51-1202.

(b) "Third party" does not include:

(I) An insurer that provides coverage under a policy of property and casualty insurance; or

(II) An insurer or entity that provides health coverage, benefits, or coverage of prescription drugs as part of coverage required under the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, or workers' compensation coverage required under federal law.

Source: L. 2022: Entire part added, (HB 22-1122), ch. 312, p. 2231, § 1, effective August 10.

10-16-1504. Applicability - exclusions. (1) This part 15 applies to any third party that reimburses 340B covered entities or contract pharmacies in this state.

(2) Nothing in this part 15:

(a) Prohibits a third party from maintaining differential reimbursement rates for participating and nonparticipating providers, so long as the rates are not determined on the basis of a provider's status as a 340B covered entity or contract pharmacy;

(b) Affects a third party's ability to establish coverage guidelines and exclude specific drugs from its prescription drug formularies, so long as the guidelines and exclusions are not determined on the basis of a provider's status as a 340B covered entity or contract pharmacy or of a drug's status as a 340B drug; or

(c) Requires a third party to contract with a 340B covered entity or contract pharmacy for purposes of participating in the third party's network, so long as the third party's contracting decisions are not determined on the basis of a provider's status as a 340B covered entity or contract pharmacy.

Source: L. 2022: Entire part added, (HB 22-1122), ch. 312, p. 2232, § 1, effective August 10.

10-16-1505. Prohibition on 340B discrimination. (1) A third party that reimburses a 340B covered entity or contract pharmacy for 340B drugs shall not:

(a) Reimburse the 340B covered entity or contract pharmacy for a pharmacy-dispensed drug at a rate lower than the amount paid for the same drug to pharmacies similar in prescription volume that are not 340B covered entities or contract pharmacies;

(b) Assess any fee, charge back, or other adjustment against the 340B covered entity or contract pharmacy on the basis that the 340B covered entity or contract pharmacy participates in the 340B program;

(c) Restrict access to the third party's pharmacy network for any 340B covered entity or contract pharmacy on the basis that the 340B covered entity or contract pharmacy participates in the 340B program;

(d) Require the 340B covered entity or contract pharmacy to enter into a contract with a specific pharmacy or health coverage plan to participate in the third party's pharmacy network;

(e) Create a restriction or an additional charge on a patient who chooses to receive drugs from a 340B covered entity or contract pharmacy;

(f) Restrict the methods by which a 340B covered entity or contract pharmacy may dispense or deliver 340B drugs;

(g) Refuse to provide reimbursement or coverage for 340B drugs; or

(h) Create any additional requirements or restrictions on a 340B covered entity or contract pharmacy.

(2) Unless a claim is for payment, directly or indirectly, by the medicaid program, a pharmacy benefit manager or any other third party that reimburses a 340B covered entity or contract pharmacy for 340B drugs shall not require a claim for a 340B drug to include:

(a) A modifier to indicate that the drug is a 340B drug; or

(b) Any other method of identifying the claim for a 340B drug.

(3) With respect to a patient eligible to receive 340B drugs, a pharmacy benefit manager or any other third party that makes payment for the drugs shall not discriminate against a 340B covered entity or contract pharmacy in a manner that prevents or interferes with the patient's choice to receive the drugs from the 340B covered entity or contract pharmacy.

Source: L. 2022: Entire part added, (HB 22-1122), ch. 312, p. 2232, § 1, effective August 10.

10-16-1506. Enforcement - rules. (1) A third party that violates this part 15 engages in an unfair or deceptive act or practice in the business of insurance under section 10-3-1104 (1)(tt), and the act of the third party that violates this part 15 is void and unenforceable.

(2) The commissioner may adopt rules as necessary to implement this part 15.

Source: L. 2022: Entire part added, (HB 22-1122), ch. 312, p. 2233, § 1, effective August 10.

ARTICLE 16.5

Prepaid Dental Care Plans

10-16.5-101 to 10-16.5-116. (Repealed)

Source: L. 92: Entire article repealed, p. 1728, § 22, effective July 1.

Editor's note: This article was added in 1979. For amendments to this article prior to its repeal in 1992, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions of this article were relocated to parts 1 and 5 of article 16 of this title. For the location of specific provisions, see the editor's notes following each section in said parts 1 and 5 and the comparative tables located in the back of the index.

HEALTH MAINTENANCE ORGANIZATIONS

ARTICLE 17

Health Maintenance Organizations

10-17-101 to 10-17-140. (Repealed)

Source: L. 92: Entire article repealed, p. 1728, § 22, effective July 1.

Editor's note: This article was numbered as article 37 of chapter 72 in C.R.S. 1963. For amendments to this article prior to its repeal in 1992, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions of this article were relocated to parts 1 and 4 of article 16 of this title. For the location of specific provisions, see the editor's notes following each section in said parts 1 and 4 and the comparative tables located in the back of the index.

MEDICARE SUPPLEMENT INSURANCE

ARTICLE 18

Medicare Supplement Insurance

Editor's note: This article was added in 1981. This article was repealed and reenacted in 1989, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this article prior to 1989, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated.

10-18-101. Definitions. As used in this article, unless the context otherwise requires:

(1) "Applicant" means:

(a) In the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; or

(b) In the case of a group medicare supplement policy or subscriber contract, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

(3) "Medicare" means the "Health Insurance for the Aged Act", Title XVIII of the federal "Social Security Act", as amended by the social security amendments of 1965, and as later amended.

(4) "Medicare supplement policy" means a group or individual policy of sickness and accident insurance or a subscriber contract of a nonprofit hospital and health service corporation or a health maintenance organization, which policy or contract is primarily advertised, marketed, or designed as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare.

Source: L. 89: Entire article R&RE, p. 498, § 1, effective July 1. **L. 92:** (4) amended, p. 1500, § 34, effective July 1.

Editor's note: This section is similar to former § 10-18-101 as it existed prior to 1989.

10-18-102. Applicability and scope. (1) Except as otherwise specifically provided, this article shall apply to:

(a) All medicare supplement policies and subscriber contracts delivered or issued for delivery in this state on or after July 1, 1989; and

(b) All certificates issued under group medicare supplement policies or subscriber contracts, which certificates have been delivered or issued for delivery in this state on or after July 1, 1989.

(2) The provisions of this article shall not apply to a policy or contract for employees, former employees, or any combination of employees or former employees or to a policy or contract for members, former members, or any combination of members and former members of labor organizations, which policy or contract is established by one or more employers or labor organizations or the trustees of a fund established by one or more employers or labor organizations or any combination of such employers, labor organizations, or trustees.

(3) The provisions of this article shall not apply to insurance policies or health-care benefit plans, including group conversion policies, provided to medicare eligible persons, which policies are not marketed as or held out to be medicare supplement policies or benefit plans.

Source: L. 89: Entire article R&RE, p. 499, § 1, effective July 1.

10-18-103. Standards for policy provisions - guarantee issue. (1) No medicare supplement insurance policy, contract, or certificate in force in this state shall contain benefits that duplicate benefits provided by medicare.

(2) The commissioner shall issue reasonable regulations to establish specific standards for policy provisions of medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with all applicable laws under this title. No requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in

this article, shall apply to medicare supplement policies. The standards shall include, but need not be limited to:

(a) Terms of renewability which shall provide that the policy cannot be canceled or nonrenewed by the insurer solely on the grounds of deterioration of health or of age;

(b) Initial and subsequent conditions of eligibility, which shall include the guaranteed issue requirements in subsection (5) of this section;

(c) Nonduplication of coverage;

(d) Preexisting conditions;

(e) Benefit limitations, exceptions, and reductions which shall not include those which are more restrictive than those of medicare for any type of care covered under the policy;

(f) Elimination, waiting, or probationary periods;

(g) Recurrent conditions;

(h) Definition of terms, including, but not limited to, accident, sickness, benefit period, hospital, nurse, physician, and skilled nursing facility;

(i) Readability standards;

(j) Continuing care coverage as required by section 10-16-413.5.

(3) The commissioner may issue reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy.

(4) Notwithstanding any other provision of law of this state to the contrary, a medicare supplement policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(5) The guaranteed issue period for a medicare supplement policy shall not be for less than six months after a previous policy has been involuntarily terminated for reasons other than nonpayment of premiums or for fraud or abuse. For purposes of this subsection (5), termination of coverage in the CoverColorado coordination of benefits plan due to the plan's termination is an involuntary termination of a previous policy.

Source: L. 89: Entire article R&RE, p. 499, § 1, effective July 1. **L. 99:** (2)(j) added, p. 1097, § 2, effective June 1. **L. 2008:** (2)(b) amended and (5) added, p. 1233, § 2, effective May 27. **L. 2013:** (5) amended, (HB 13-1115), ch. 338, p. 1972, § 13, effective May 28.

Editor's note: This section is similar to former § 10-18-102 as it existed prior to 1989.

10-18-104. Minimum standards for benefits and claims payment. The commissioner shall issue reasonable regulations to establish minimum standards for benefits and payment of claims under medicare supplement policies.

Source: L. 89: Entire article R&RE, p. 500, § 1, effective July 1.

Editor's note: This section is similar to former § 10-18-103 as it existed prior to 1989.

10-18-105. Loss ratio standards and filing requirements. (1) Every insurer providing group or individual medicare supplement insurance benefits to a resident of this state pursuant to section 10-18-102 shall file a copy of the group master policy or individual policy and any certificate used in this state in accordance with the filing requirements and procedures of sections 10-16-107.2 and 10-16-406; except that no insurer shall be required to make a filing earlier than thirty days after insurance was provided to a resident of this state under a group master policy issued for delivery outside this state.

(2) Group and individual medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience or incurred health-care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and on the basis of earned premiums in accordance with accepted actuarial principles and practices. Every entity providing medicare supplement policies or certificates in this state shall file annually its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state. All filings of rates and rating schedules shall demonstrate that the actual and expected losses in relation to premiums comply with the requirements of this article.

(3) No entity shall provide compensation to its agents or other producers which is greater than the renewal compensation which would have been paid on an existing policy if the existing policy had been replaced by another policy with the same company and the new policy benefits had been substantially similar to the benefits under the old policy and the old policy had been issued by the same insurer or insurer group.

Source: L. 89: Entire article R&RE, p. 500, § 1, effective July 1. **L. 92:** (1) amended, p. 1725, § 10, effective July 1. **L. 2013:** (1) amended, (HB 13-1266), ch. 217, p. 990, § 55, effective May 13.

Editor's note: This section is similar to former § 10-18-104 as it existed prior to 1989.

10-18-106. Disclosure standards - regulations necessary for compliance with federal law. (1) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no individual medicare supplement policy or certificate shall be delivered or issued for delivery in this state unless the outline of coverage as described in subsection (2) of this section is delivered to the applicant for such policy or such certificate at the time application is made.

(2) The commissioner shall prescribe by regulation the format and content of the outline of coverage required by subsection (1) of this section. As used in this subsection (2), "format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the exceptions, reductions, and limitations contained in the policy;

(c) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;

(d) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(e) (Deleted by amendment, L. 92, p. 1605, § 144, effective May 20, 1992.)

(3) The commissioner may further prescribe by regulation a standard form for and the contents of an informational brochure for persons eligible for medicare by reason of age, which brochure is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by regulation that the information brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response medicare supplement insurance policies, the commissioner may require by regulation that the prescribed brochure must be provided upon request to any prospective insureds eligible for medicare by reason of age, but in no event later than the time of policy delivery.

(4) The commissioner may promulgate regulations for captions or notice requirements determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages for all accident and sickness insurance policies sold to persons eligible for medicare by reason of age, which policies fail to meet the definition of a medicare supplement policy in section 10-18-101 (4).

(5) The commissioner may promulgate such regulations as are necessary to allow Colorado to meet the medicare supplement policy standards and requirements imposed by the federal "Health Insurance for the Aged Act" or otherwise required by any federal law or rule or regulation. This shall include the authority to promulgate as regulations the model standards adopted by the national association of insurance commissioners for the purpose of complying with any such federal requirements.

Source: L. 89: Entire article R&RE, p. 501, § 1, effective July 1. **L. 91:** (5) added, p. 1181, § 1, effective March 27. **L. 92:** (2)(e) and (3) amended, p. 1605, § 144, effective May 20.

Cross references: For the federal "Health Insurance for the Aged Act", see Title I of Pub.L. 89-97.

10-18-107. Right to examine policy - right to refund of premium. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty days after its delivery and to have any premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the policyholder or certificate holder by the insurer in a timely manner. If a policyholder or certificate holder decides to cancel a policy or certificate after the first thirty days of coverage and the policyholder or certificate holder provides the insurer notice of the cancellation at least thirty days before cancellation, the insurer shall refund a prorated amount of any prepaid premiums for such policy or certificate based on the subsequent full months of coverage being canceled.

Source: L. 89: Entire article R&RE, p. 502, § 1, effective July 1. **L. 2002:** Entire section amended, p. 305, § 1, effective January 1, 2003.

Editor's note: This section is similar to former § 10-18-107 as it existed prior to 1989.

10-18-108. Advertising - copy provided to commissioner. Every insurer, health-care service plan, or other entity providing medicare supplement insurance or benefits in this state that advertises medicare supplement insurance shall provide the commissioner a written copy of the medicare supplement advertisement used in this state. If there is a complaint filed about a radio or television advertisement, the commissioner may request an audio or video recording from those entities.

Source: L. 89: Entire article R&RE, p. 502, § 1, effective July 1. **L. 2022:** Entire section amended, (SB 22-212), ch. 421, p. 2967, § 19, effective August 10.

10-18-109. Penalties. In addition to any other applicable penalties for violations of this title, the commissioner may order insurers violating any provision of this article or regulations promulgated pursuant to this article to cease marketing any medicare supplement policy or certificate in this state, which policy or certificate is related directly or indirectly to a violation, may order such insurers to take such actions as are necessary to comply with the provisions of this article, or may make both such orders.

Source: L. 89: Entire article R&RE, p. 502, § 1, effective July 1.

LONG-TERM CARE

ARTICLE 19

Long-term Care Insurance

Editor's note: This article was added in 1986. This article was repealed and reenacted in 1990, resulting in the addition, relocation, and elimination of sections as well as subject matter. For amendments to this article prior to 1990, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated.

10-19-101. Short title. This article shall be known and may be cited as the "Long-term Care Insurance Act".

Source: L. 90: Entire article R&RE, p. 643, § 1, effective July 1.

10-19-102. Legislative declaration. The general assembly hereby declares that the purpose of this article is to promote the public interest and the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive

sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Source: L. 90: Entire article R&RE, p. 643, § 1, effective July 1.

10-19-103. Definitions. As used in this article 19, unless the context otherwise requires:

(1) "Applicant" means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(b) In the case of a group long-term care insurance policy, the proposed certificate holder.

(1.5) Repealed.

(2) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(3) "Commissioner" means the commissioner of insurance.

(3.5) "Dementia diseases and related disabilities" has the same meaning set forth in section 10-16-102 (16.5).

(4) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to one of the following:

(a) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations;

(b) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:

(I) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(II) Has been maintained in good faith for purposes other than obtaining insurance;

(c) (I) An association or a trust or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering such policy within this state, the association or the insurer of the association shall file evidence with the commissioner that the association has at the outset a minimum of one hundred persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for at least one year, and has a constitution and bylaws which provide that:

(A) The association holds regular meetings not less than annually to further purposes of the members;

(B) Except for credit unions, the association collects dues or solicits contributions from members; and

(C) The members have voting privileges and representation on the governing board and committees.

(II) Thirty days after such filing, the association will be deemed to satisfy such organizational requirements, unless the commissioner makes a finding that the association does not satisfy those organizational requirements.

(d) A group other than as described in paragraph (a), (b), or (c) of this subsection (4), subject to a finding by the commissioner that:

(I) The issuance of the group policy is not contrary to the best interest of the public;

(II) The issuance of the group policy would result in economies of acquisition or administration; and

(III) The benefits are reasonable in relation to the premiums charged.

(5) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. "Long-term care insurance" includes group and individual annuities and life insurance policies or riders that provide directly or that supplement long-term care insurance. The term shall also include qualified long-term care insurance contracts. This term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. "Long-term care insurance" also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit hospital, medical-surgical, and health service corporations, prepaid health plans, health maintenance organizations, or any similar organizations to the extent they are otherwise authorized to issue life or health insurance. "Long-term health-care insurance" shall not include any insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited-benefit health coverage. Notwithstanding any other provisions contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this article.

(6) "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit hospital, medical-surgical, or health service corporation, prepaid health plan, health maintenance organization, or any similar organization.

(7) Repealed.

(8) (a) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of 26 U.S.C. sec. 7702B (b) of the federal "Internal Revenue Code of 1986", as amended, as follows:

(I) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subparagraph (I) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(II) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the federal "Social Security Act", as added by the "Social Security Amendments of 1965", Pub.L. 89-97, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph (II) do not apply to expenses that are reimbursable under said Title XVIII only as a secondary payer. A contract shall not fail to satisfy the requirements of this subparagraph (II) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(III) The contract is guaranteed renewable, within the meaning of 26 U.S.C. sec. 7702B (b)(1)(C) of the federal "Internal Revenue Code of 1986", as amended;

(IV) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subparagraph (V) of this paragraph (a);

(V) All refunds of premiums and all policyholder dividends or similar amounts under the contract are to be applied as a reduction in future premiums or to increase future benefits; except that a cash refund may be issued in the event of death of the insured or a complete surrender or cancellation of the contract, so long as the refund does not exceed the aggregate premiums paid under the contract;

(VI) The contract meets the consumer protection provisions set forth in 26 U.S.C. sec. 7702B (g) of the federal "Internal Revenue Code of 1986", as amended.

(b) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of 26 U.S.C. sec. 7702B (b) and (e) of the federal "Internal Revenue Code of 1986", as amended.

Source: L. 90: Entire article R&RE, p. 643, § 1, effective July 1. **L. 95:** (5) amended and (1.5) and (7) added, p. 922, § 20, effective May 25. **L. 2005:** (1.5) and (7) repealed, p. 405, § 1, effective August 8. **L. 2007:** (5) amended and (8) added, p. 196, § 1, effective January 1, 2008. **L. 2018:** IP amended and (3.5) added, (HB 18-1091), ch. 74, p. 645, § 10, effective August 8.

Editor's note: This section is similar to former § 10-19-101 as it existed prior to 1990.

10-19-104. Scope and applicability of article. The requirements of this article shall apply to policies delivered or issued for delivery in this state on or after July 1, 1990. This article is not intended to supersede the obligations of entities subject to this article to comply with the substance of other applicable insurance laws insofar as they do not conflict with this article; except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance.

Source: L. 90: Entire article R&RE, p. 645, § 1, effective July 1. **L. 2007:** Entire section amended, p. 198, § 2, effective January 1, 2008.

10-19-105. Extraterritorial jurisdiction - group long-term care insurance. A group long-term care insurance coverage shall not be offered to a resident of this state under a group

policy issued in another state to a group described in section 10-19-103 (4)(d), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Source: L. 90: Entire article R&RE, p. 645, § 1, effective July 1.

10-19-106. Rules on disclosure. The commissioner may adopt rules and regulations that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms. Such rules and regulations shall be in accordance with the "State Administrative Procedure Act", article 4 of title 24, C.R.S.

Source: L. 90: Entire article R&RE, p. 645, § 1, effective July 1.

10-19-107. Performance standards. (1) A long-term care insurance policy may not:

(a) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

(b) Contain a provision establishing a new waiting period in the event that existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care; or

(d) Exclude coverage for dementia diseases and related disabilities.

(2) A long-term care insurance policy shall:

(a) Offer the policyholder the opportunity to designate an individual who can be contacted in the event the policy is about to lapse. If the policyholder declines to designate someone, the carrier shall obtain a signed statement that the policyholder has been offered this opportunity and declined. The policyholder has the right to periodically update his or her authorized designee.

(b) Provide a ninety-day reinstatement period for policyholders who have allowed their policies to lapse due to nonpayment of premium, who have a cognitive impairment, and who have regularly paid the required premiums. The reinstated policy shall provide the same benefits, terms, and premiums as the lapsed policy.

Source: L. 90: Entire article R&RE, p. 646, § 1, effective July 1. **L. 95:** (2) added, p. 923, § 21, effective May 25. **L. 2007:** (1)(c) amended, p. 198, § 3, effective January 1, 2008. **L. 2018:** (1)(d) amended, (HB 18-1091), ch. 74, p. 645, § 11, effective August 8.

10-19-108. Requirements for preexisting conditions. (1) A long-term care insurance policy or certificate, other than a policy or certificate thereunder, issued to a group as defined in

section 10-19-103 (4)(a), shall not use a definition of "preexisting condition" that is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health-care services within six months preceding the effective date of coverage of an insured person.

(2) A long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group as defined in section 10-19-103 (4)(a), shall not exclude coverage for a loss or confinement which is the result of a preexisting condition, unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods set forth in subsections (1) and (2) of this section to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" in subsection (1) of this section does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on the application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (2) of this section expires. A long-term care insurance policy or certificate shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (2) of this section.

Source: L. 90: Entire article R&RE, p. 646, § 1, effective July 1. **L. 95:** (1) amended, p. 923, § 22, effective May 25. **L. 2007:** (1), (2), and (4) amended, p. 198, § 4, effective January 1, 2008.

10-19-109. Requirements for prior hospitalization or institutionalization. (1) A long-term care insurance policy shall not be delivered or issued for delivery in this state if such policy:

(a) Conditions the eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions the eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(2) (a) A long-term care insurance policy containing any limitations or conditions on eligibility for post-confinement, post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(b) Effective July 1, 1991, a long-term care insurance policy containing a benefit advertised, marketed, or offered as a home health care or home care benefit shall not condition receipt of benefits on a prior institutionalization requirement.

(c) A long-term care insurance policy that conditions eligibility for noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days.

(3) A long-term care insurance policy which provides benefits only following institutionalization shall not condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

Source: L. 90: Entire article R&RE, p. 647, § 1, effective July 1. **L. 2007:** (1), (2)(a), and (2)(c) amended, p. 199. § 5, effective January 1, 2008.

10-19-110. Loss ratio standards. The commissioner may adopt rules and regulations establishing loss-ratio standards for long-term care insurance policies if a specific reference to long-term care insurance policies is contained in the regulation. Such rules and regulations shall be in accordance with the "State Administrative Procedure Act", article 4 of title 24, C.R.S.

Source: L. 90: Entire article R&RE, p. 647, § 1, effective July 1.

10-19-111. Right to return policy - free look. A long-term care insurance applicant has the right to return the policy or certificate within thirty days after its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in section 10-19-103 (4)(a), the applicant is not satisfied for any reason. A long-term care insurance policy or certificate shall contain a notice, prominently printed on the first page or attached thereto, stating in substance that the applicant has the right to return the policy or certificate within thirty days after its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in section 10-19-103 (4)(a), the applicant is not satisfied for any reason. This section shall also apply to a denial of application. Any refund shall be made within thirty days after the return or denial.

Source: L. 90: Entire article R&RE, p. 647, § 1, effective July 1. **L. 2007:** Entire section amended, p. 199, § 6, effective January 1, 2008.

10-19-112. Outline of coverage - certificate. (1) (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(b) The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.

(c) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(d) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(e) In the case of a policy issued to a group defined in section 10-19-103 (4)(a), an outline of coverage shall not be required to be delivered if the information described in

subsection (2) of this section is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

(2) The outline of coverage shall include all of the following:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains the governing contractual provisions;

(e) A description of the terms under which the policy or certificate may be returned and premium refunded;

(f) A brief description of the relationship of cost of care and benefits;

(g) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 26 U.S.C. sec. 7702B (b) of the federal "Internal Revenue Code of 1986", as amended.

(3) A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement that the group master policy determines governing contractual provisions; and

(d) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(4) (Deleted by amendment, L. 2007, p. 200, § 8, effective January 1, 2008.)

(5) Any policy or rider that is advertised, marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of this article.

(6) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty days after the date of approval.

(7) (a) Prior to the sale of an individual life insurance policy that provides long-term care benefits either within the policy or by rider, a policy summary shall be delivered to the applicant. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than the time of the sale of the policy. In addition to complying with all applicable requirements, the summary shall also include:

(I) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(II) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

(III) Any exclusions, reductions, or limitations on benefits of long-term care;

(IV) A statement that any long-term care inflation protection option required by section 10-19-113 is not available under the policy.

(b) If applicable to the policy type, the summary shall also include:

(I) A disclosure of the effects of exercising other rights under the policy;

(II) A disclosure of guarantees related to long-term care costs of insurance charges; and

(III) Current and projected maximum lifetime benefits.

(c) The provisions of the policy summary listed in paragraphs (a) and (b) of this subsection (7) may be incorporated into a basic illustration or into the life insurance policy summary.

(8) Whenever a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(a) Any long-term care benefits paid out during the month;

(b) An explanation of any changes in the policy, such as death benefits or cash values, due to long-term care benefits being paid out; and

(c) The amount of long-term care benefits existing or remaining.

(9) If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

(a) Provide a written explanation of the reasons for the denial; and

(b) Make available all information directly related to the denial.

Source: L. 90: Entire article R&RE, p. 648, § 1, effective July 1. **L. 95:** (4) and (5) added, p. 924, § 23, effective May 25. **L. 2007:** (1)(e), (2)(g), (6), (7), (8), and (9) added and (4) and (5) amended, pp. 200, 202, §§ 7, 9, 8, effective January 1, 2008.

10-19-113. Option for inflation adjustment - renewability. (1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations that are meaningful to account for reasonable anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(a) The inflation protection feature increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent;

(b) The inflation protection feature guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) The inflation protection feature covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) If the policy is issued to a group, the required offer in subsection (1) of this section shall be made to the group policyholder; except that, if the policy is issued to a group defined in section 10-19-103 (4)(d) other than a continuing care retirement community, the offer shall be made to each proposed certificate holder.

(3) The offer in subsection (1) of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(4) (a) An insurer shall include the following information in or with the outline of coverage:

(I) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with the benefit levels of a comparable policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period.

(II) Any expected premium increase or additional premium to pay for automatic or optional benefit increases.

(b) An insurer may use a reasonable hypothetical or graphic demonstration for the purposes of the disclosure required by this subsection (4).

(5) Inflation protection benefit increases under a policy that contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the time the person has been insured under the policy.

(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The offer shall disclose, in a conspicuous manner, that the premium may change in the future unless the premium is guaranteed to remain constant.

(7) (a) Inflation protection as provided in subsection (1) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection (7). The rejection may be either in the application or on a separate form.

(b) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plans _____, and I reject inflation protection.

Source: L. 90: Entire article R&RE, p. 649, § 1, effective July 1. **L. 2007:** Entire section amended, p. 202, § 10, effective January 1, 2008.

10-19-113.3. Incontestability period. (1) With respect to a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny a long-term care insurance claim under such a policy upon a showing of misrepresentation that is material to the acceptance for coverage.

(2) With respect to a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and pertains to the condition for which

benefits are sought. A policy or certificate that has been in force for two years shall not be contested solely on the grounds of misrepresentation. Such a policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(3) No long-term care insurance policy or certificate may be field issued based on medical or health status. For purposes of this subsection (3), "field issued" means a policy or certificate is issued by a producer or third-party administrator pursuant to the underwriting authority granted to the producer or third-party administrator by a carrier and using the insurer's underwriting guidelines.

(4) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payment may not be recovered by the insurer in the event that the policy or certificate is rescinded.

(5) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In that situation, the remaining death benefits under the policies shall be governed by sections 10-7-102 and 10-7-202. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Source: L. 95: Entire section added, p. 924, § 24, effective May 25. **L. 2007:** (3) and (4) amended and (5) added, p. 204, § 11, effective January 1, 2008.

10-19-113.4. Nonforfeiture benefits - rules. (1) Except as provided in subsection (2) of this section, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period.

(2) When a group long-term care insurance policy is issued, the offer required in subsection (1) of this section shall be made to the group policyholder; except that, if the policy is issued as group long-term care insurance as defined in section 10-19-103 (4)(d), other than to a continuing care retirement community or other similar entity, the offer shall be made to each proposed certificate holder.

(3) The commissioner shall promulgate rules specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection (1) of this section.

Source: L. 2007: Entire section added, p. 204, § 12, effective January 1, 2008.

10-19-113.5. Requirement to offer basic and standard long-term care plans - advisory committee established. (Repealed)

Source: L. 95: Entire section added, p. 924, § 24, effective May 25. **L. 96:** (1) amended, p. 120, § 1, effective March 25. **L. 2005:** Entire section repealed, p. 405, § 2, effective August 8.

10-19-113.6. Producer training requirements. (1) (a) An individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health or sickness or life insurance and has completed a one-time training course and ongoing training every twenty-four months. The training must meet the requirements set forth in subsection (2) of this section.

(b) The training requirements of subsection (2) of this section may be approved as continuing education courses under section 10-2-301.

(2) (a) The one-time training required by this section shall be no less than sixteen hours, eight hours of which shall consist of long-term care, generally, and eight hours of which shall be specific to long-term care partnerships in a classroom setting. The ongoing training required by this section shall be no less than five hours in a classroom setting.

(b) The training required under paragraph (a) of this subsection (2) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance partnership programs, including, but not limited to:

(I) State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including medicaid;

(II) Available long-term care services and providers;

(III) Changes or improvements in long-term care services or providers;

(IV) Alternatives to the purchase of private long-term care insurance;

(V) The effect of inflation on benefits and the importance of inflation protection; and

(VI) Consumer suitability standards and guidelines.

(c) The training required by this section shall not include training that is insurer- or company product-specific or that includes any sales or marketing information, materials, or training other than those required by state or federal law.

(3) (a) Each insurer subject to this article shall obtain verification that a producer receives training required by paragraph (a) of subsection (1) of this section before the producer is permitted to sell, solicit, or negotiate the insurer's long-term care insurance products. The insurer shall maintain records in accordance with all applicable record retention requirements and shall make the verification available to the commissioner upon request.

(b) Each insurer subject to this article shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the division of insurance to provide assurance to the state medicaid agency that producers have received the training contained in subparagraph (I) of paragraph (b) of subsection (2) of this section, as required by paragraph (a) of subsection (1) of this section, and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including medicaid, in this state. These records shall be maintained in accordance with all applicable record retention requirements and shall be made available to the commissioner upon request.

(4) The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this state.

Source: L. 2007: Entire section added, p. 205, § 12, effective January 1, 2008. **L. 2017:** (1)(a) amended, (SB 17-249), ch. 283, p. 1550, § 20, effective June 1.

Cross references: For more information concerning medicaid, see title 25.5.

10-19-113.7. Rules. The commissioner shall adopt rules to promote premium adequacy, to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, producer education, producer compensation, producer examination, penalties, and reporting practices for long-term care insurance. In addition, the commissioner may issue regulations to establish minimum standards concerning suitability.

Source: L. 95: Entire section added, p. 924, § 24, effective May 25. **L. 96:** Entire section amended, p. 1354, § 1, effective June 1. **L. 2005:** Entire section amended, p. 406, § 3, effective August 8. **L. 2007:** Entire section amended, p. 206, § 13, effective January 1, 2008.

10-19-114. Compliance. No policy may be advertised, marketed, or offered as long-term care or nursing home insurance unless it complies with the provisions of this article.

Source: L. 90: Entire article R&RE, p. 649, § 1, effective July 1.

10-19-114.5. Penalties. In addition to any other penalties provided by the laws of Colorado, any carrier or any producer who violates any requirement of Colorado law relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

Source: L. 95: Entire section added, p. 924, § 24, effective May 25.

10-19-115. Severability. If any provision of this article or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the article and the application of such provision to other persons or circumstances shall not be affected thereby.

Source: L. 90: Entire article R&RE, p. 649, § 1, effective July 1.

LIFE AND HEALTH INSURANCE PROTECTION

ARTICLE 20

Life and Health Insurance
Protection Association

Law reviews: For article, "1991 Life and Health Insurer Solvency Legislation", see 20 Colo. Law. 1767 (1991).

10-20-101. Short title. The short title of this article 20 is the "Life and Health Insurance Protection Association Act".

Source: L. 91: Entire article added, p. 1256, § 1, effective July 1. **L. 2023:** Entire section amended, (HB 23-1303), ch. 195, p. 978, § 2, effective May 15.

10-20-102. Legislative declaration. (1) The general assembly finds and declares that the purpose of this article 20 is to protect, subject to certain limitations, the persons specified in section 10-20-104 (1) against failure by member insurers in the performance of their contractual obligations under life insurance policies, health insurance policies, health benefit plans, and annuity policies, plans, or contracts specified in section 10-20-104 (2) because of the insolvency of the member insurer that issued the policies, plans, or contracts.

(2) To provide the protection specified in subsection (1) of this section, an association of member insurers shall be created and shall exist to pay benefits and to continue coverages as limited pursuant to this article 20. Member insurers of the association are subject to assessment to provide funds to carry out the purpose of this article 20.

Source: L. 91: Entire article added, p. 1256, § 1, effective July 1. **L. 2023:** Entire section amended, (HB 23-1303), ch. 195, p. 978, § 3, effective May 15.

10-20-103. Definitions. As used in this article 20, unless the context otherwise requires:

(1) "Account" means any of the three accounts created pursuant to section 10-20-106.

(2) "Association" means the life and health insurance protection association as established by this article.

(2.5) "Authorized assessment" or "authorized" when used in the context of assessments means a resolution passed by the board in which an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution pertaining to the assessment is passed.

(3) "Board" means the board of the association.

(3.5) "Called assessment" or "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid by the date set in the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(4) "Commissioner" means the commissioner of insurance.

(5) "Contractual obligation" means any obligation under a policy, contract, or certificate under a group policy or contract, or portion thereof, for which coverage is provided pursuant to section 10-20-104.

(6) "Covered policy", "covered contract", or "covered policy or contract" means a policy or contract, or a portion of a policy or contract, for which coverage is provided under section 10-20-104.

(6.5) "Extracontractual claims" includes claims relating to bad faith in the payment of claims, claims for punitive or exemplary damages, and claims for attorney fees and costs.

(6.6) (a) "Health benefit plan" means any hospital or medical expense policy or certificate, health maintenance organization subscriber contract, or other similar health contract

that is subject to the jurisdiction of the commissioner and available for use, offered, or sold in Colorado.

(b) "Health benefit plan" does not include:

(I) An accident only plan;

(II) Credit insurance;

(III) Dental insurance;

(IV) Vision insurance;

(V) A medicare supplement plan;

(VI) Benefits for long-term care, home health care, community-based care, or any combination of such benefits;

(VII) Disability income insurance;

(VIII) Liability insurance including general liability insurance and automobile liability insurance;

(IX) Coverage for on-site medical clinics;

(X) Coverage issued as a supplement to liability insurance, workers' compensation, or similar insurance;

(XI) Automobile medical payment insurance; or

(XII) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the type of coverage does not provide coordination of benefits and is provided under a separate policy or certificate.

(6.7) "Impaired insurer" means a member insurer that is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(7) "Insolvent insurer" means a member insurer which after July 1, 1991, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(8) "Member insurer" means any insurer or health maintenance organization that is licensed or holds a certificate of authority in this state to write any kind of insurance or health maintenance organization business for which coverage is provided pursuant to section 10-20-104 and includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn. "Member insurer" does not include:

(a) A nonprofit hospital or medical service organization;

(b) Repealed.

(c) A fraternal benefit society;

(d) A mandatory state pooling plan;

(e) Repealed.

(f) A stipulated premium insurance company;

(g) A local mutual burial association;

(h) A mutual assessment company or any entity that operates on an assessment basis;

(i) An interinsurance exchange;

(i.5) A health-care coverage cooperative with a certificate of authority issued and operating under part 10 of article 16 of this title 10; or

(j) Any entity similar to those specified in subsections (8)(a) to (8)(i.5) of this section.

(9) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(10) "NAIC" means the national association of insurance commissioners.

(10.5) "Owner" of a policy or contract, "policy owner", "policyholder", "contract holder", or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms "owner", "contract owner", "policyholder", "contract holder", and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

(11) "Person" means any individual, corporation, limited liability company, partnership, association, or voluntary organization.

(12) (a) "Premiums" means the amount of money or other consideration, however designated, received on covered policies or contracts less returned premiums, returned consideration, and returned deposits, and less dividends and experience credits.

(b) "Premiums" does not include:

(I) Any amount of money or other consideration received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 10-20-104 (2); except that assessable premiums shall not be reduced on account of section 10-20-104 (2)(b)(III) relating to interest limitations and section 10-20-104 (3)(b) relating to limitations with respect to any one life;

(II) Premiums on an unallocated annuity contract; or

(III) Premiums in excess of five million dollars with respect to multiple nongroup policies of life insurance owned by one owner, regardless of:

(A) Whether the policy owner is an individual, firm, corporation, or other person;

(B) Whether the persons insured are officers, managers, employees, or other persons; or

(C) The number of policies or contracts held by the owner.

(12.5) (a) "Principal place of business" of a person other than an individual means the single state in which the individuals who establish policy for the direction, control, and coordination of the operation of the entity as a whole primarily exercise that function, as determined by the association in its reasonable judgment by considering the following factors:

(I) The state in which the primary executive and administrative headquarters of the entity is located;

(II) The state in which the principal office of the chief executive officer of the entity is located;

(III) The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;

(IV) The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; and

(V) The state from which the overall operation of the entity is directed.

(b) In the case of plan sponsors, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state is the principal place of business for the plan sponsor.

(c) The principal place of business of a plan sponsor of a benefit plan is the principal place of business of the association, committee, joint board of trustees, or similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific

or clear designation of a principal place of business, is the principal place of business of the employer or employee organization that has the largest investment in the benefit plan.

(12.7) "Receivership court" means the court in an impaired or insolvent insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

(13) "Resident" means any person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person must be a resident of only one state, which, in the case of a person other than a natural person, must be its principal place of business. Citizens of the United States who are residents of a foreign country, United States possession, United States territory, or United States protectorate, which country, possession, territory, or protectorate does not have an association similar to the association created by this article 20, are deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(13.3) "State" means a state, the District of Columbia, Puerto Rico, or a possession, territory, or protectorate of the United States.

(13.5) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(14) "Supplemental contract" means any written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or a life, health, or annuity contract.

(15) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Source: L. 91: Entire article added, p. 1257, § 1, effective July 1. **L. 2000:** (10.5), (13.5), and (15) added and (13) amended, p. 1017, § 1, effective July 1. **L. 2001:** (8)(e) amended, p. 1051, § 38, effective July 1. **L. 2004:** (8)(i) amended and (8)(i.5) added, p. 1009, § 15, effective August 4. **L. 2013:** (2.5), (3.5), (6.5), (6.7), (12.5), (12.7), and (13.3) added and (6), (9), (11), (12), (13), and (14) amended, (SB 13-032), ch. 34, p. 81, § 1, effective March 15; (8)(e) amended, (HB 13-1115), ch. 338, p. 1973, § 14, effective May 28. **L. 2023:** IP, (6), IP(8), (8)(i.5), (8)(j), (10.5), (12), (12.7), and (13) amended, (6.6) added, and (8)(b) repealed, (HB 23-1303), ch. 195, p. 978, § 4, effective May 15.

Editor's note: Subsection (8)(e)(II) provided for the repeal of subsection (8)(e), effective March 31, 2015. (See L. 2013, p. 1973.)

10-20-104. Coverage and limitations - coordination of benefits. (1) This article 20 provides coverage for the policies and contracts specified in subsection (2) of this section and to persons:

(a) Who are owners of, certificate holders under, or enrollees in such policies or contracts, other than structured settlement annuities, and who:

(I) Are residents; or

(II) Are not residents, but only under all of the following conditions:

(A) The member insurer that issued the policies or contracts is domiciled in this state;

(B) The member insurer never held a license or certificate of authority in the states in which such persons reside;

(C) Such states have associations similar to the association created by this article; and

(D) Such persons are not eligible for any amount of coverage by such associations;

(b) Regardless of where they reside, except for nonresident certificate holders under group policies or contracts, who are the beneficiaries, assignees, or payees, including health-care providers rendering services under a health insurance or health maintenance organization policy, contract, or certificate, of the persons covered under subsection (1)(a) of this section.

(1.3) Subsection (1) of this section shall not apply to structured settlement annuities. Except as otherwise provided in subsections (1.5) and (1.7) of this section, this article shall provide coverage to a person who is a payee under a structured settlement annuity or to a beneficiary of a deceased payee if the payee:

(a) Is a resident, regardless of where the contract owner resides; or

(b) Is not a resident, but only under both of the following conditions:

(I) Either:

(A) The contract owner of the structured settlement annuity is a resident; or

(B) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by this article; and

(II) Neither the payee, the beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(1.5) This article 20 does not provide coverage to a person that:

(a) Is a payee or beneficiary of an owner or enrollee who is a resident of this state if the payee or beneficiary is afforded any coverage by the association of another state; or

(b) Acquires rights to receive payments through a structured settlement factoring transaction, as defined in 26 U.S.C. sec. 5891 (c)(3)(A), regardless of whether the transaction occurred before, on, or after the effective date of 26 U.S.C. sec. 5891 (c)(3)(A).

(1.7) This article 20 is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this article 20 is provided coverage under the laws of any other state, the person shall not be provided coverage under this article 20. In determining the application of the provisions of this subsection (1.7) in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, enrollee, or assignee, this article 20 shall be construed in conjunction with other state laws to result in coverage by only one association.

(2) (a) This article 20 provides coverage to the persons specified in subsections (1) and (1.3) of this section for direct, nongroup life insurance, health insurance, health maintenance organization, annuity, and supplemental policies or contracts and for certificates under direct group life insurance, health insurance, health maintenance organization, or annuity policies or contracts, and for supplemental contracts to any of these, issued by member insurers pursuant to article 7 and parts 1, 2, and 4 of article 16 of this title 10, except as limited by this article 20. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(b) Except as otherwise provided in subsection (2)(c) of this section, this article 20 does not provide coverage for:

(I) Any portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

(II) Any policy or contract of reinsurance, unless assumption certificates have been issued under the reinsurance policy or contract;

(III) Any portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or other factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns and changes in value:

(A) When averaged over the period of four years prior to the date on which the association became obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average, averaged for that same four-year period, or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

(B) On and after the date on which the association became obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

(IV) Any portion of a policy, contract, plan, or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(A) A multiple employer welfare arrangement, as defined in section 1002 of title 29 of the United States Code;

(B) A minimum premium group insurance plan;

(C) A stop-loss group insurance plan; or

(D) An administrative services only contract;

(V) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, voting rights, or that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract;

(VI) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;

(VII) Any unallocated annuity contract;

(VIII) Any annuity contract or group annuity certificate which is used by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees for the purpose of providing retirement benefits;

(IX) Any policy, contract, certificate, or subscriber agreement issued by a prepaid dental care plan as defined in parts 1 and 5 of article 16 of this title;

(X) Services covered under a policy of sickness and accident insurance as defined in section 10-16-102 (50) when written by a property and casualty insurer as part of an automobile insurance contract;

(XI) Repealed.

(XII) Any member insurer that was insolvent or unable to fulfill its contractual obligations as of July 1, 1991; except that an annuity contract issued or assumed by such a member insurer shall be covered under this article 20 if the member insurer was ordered into liquidation between July 1, 1991, and August 31, 1991;

(XIII) Repealed.

(XIV) Any portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract but such changes have not been credited to the policy or contract, or to the extent the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this article. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this section, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of insolvency, and such interest or changes shall not be subject to forfeiture.

(XV) Repealed.

(XVI) Any policy or contract providing hospital, medical, prescription drug, or other health-care benefits under:

(A) Part C or part D of subchapter XVIII, chapter 7 of title 42, United States Code, or any regulation issued under those parts C or D; or

(B) Subchapter XIX, chapter 7 of title 42, United States Code, or any regulation issued under Subchapter XIX;

(XVII) Any portion of a policy or contract to the extent that the assessment required by this article with respect to the policy or contract are preempted or otherwise not allowed by federal or state law;

(XVIII) Any obligation that does not arise under the expressed written terms of the policy or contract issued by the member insurer to the owner, certificate holder, or enrollee, including:

(A) Claims based on marketing materials, brochures, illustrations, advertisements, or oral statements by agents, brokers, or others used or made in connection with the sale of covered policies and contracts;

(B) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) Misrepresentations of, or regarding, policy or contract benefits;

(D) Extracontractual claims; and

(E) Claims for penalties, interest, or consequential or incidental damages;

(XIX) Any contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by a benefit plan or trustee that is not an affiliate of the member insurer;

(XX) Structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction, as defined in 26 U.S.C. sec. 5891 (c)(3)(A), regardless of whether the transaction occurred before, on, or after the effective date of 26 U.S.C. sec. 5891 (c)(3)(A).

(c) The exclusions from coverage specified in subsection (2)(b)(III) of this section do not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

(3) The benefits for which the association may become liable must not exceed the lesser of:

(a) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b) (I) With respect to any one life, regardless of the number of policies or contracts with that member insurer:

(A) Three hundred thousand dollars in net life insurance death benefits, and no more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(B) For health insurance benefits or coverage received under health maintenance organization contracts: One hundred thousand dollars for coverages not defined as disability, coverage or services under health benefit plans, or long-term care insurance, including any net cash surrender and net cash withdrawal values; three hundred thousand dollars for disability insurance; three hundred thousand dollars for long-term care insurance; or five hundred thousand dollars for coverage or services under health benefit plans;

(C) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(D) With respect to each payee of a structured settlement annuity, two hundred fifty thousand dollars in present-value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values.

(E) (Deleted by amendment, L. 2013.)

(II) The association is not obligated to cover:

(A) More than three hundred thousand dollars in benefits, in the aggregate, with respect to any one life under subsection (3)(b)(I) of this section; except that, with respect to benefits for coverage or services under health benefit plans under subsection (3)(b)(I)(B) of this section, the aggregate liability of the association must not exceed five hundred thousand dollars with respect to any one life; or

(B) More than five million dollars in benefits with respect to an owner of multiple nongroup policies of life insurance, regardless of whether the policy owner is an individual, firm, corporation, or other person; whether the persons insured are officers, managers, employees, or other persons; or the number of policies and contracts held by the owner.

(c) The limitations set forth in this subsection (3) are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this subsection (3) may be met by the use of assets attributable to covered policies or reimbursed to the association under its subrogation and assignment rights.

(3.5) For purposes of this article 20, benefits provided by a long-term care rider to a life insurance policy or annuity are considered the same type of benefits as the benefits provided by the underlying life insurance policy or annuity contract to which the rider relates.

(4) In performing its obligations to provide coverage under section 10-20-108, the association is not required to guarantee, assume, reinsure, reissue, or perform, or cause to be

guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the impaired or insolvent insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Source: L. 91: Entire article added, p. 1258, § 1, effective July 1. **L. 92:** (2)(a), (2)(b)(IX), and (2)(b)(X) amended, p. 1725, § 11, effective July 1. **L. 94:** (2)(b)(XII) amended, p. 614, § 1, effective April 13. **L. 2000:** IP(1)(a), (2)(b)(III), (2)(b)(VII), (2)(b)(XIII), (2)(b)(XIV), and (3)(b) amended and (1.3), (1.5), and (1.7) added, p. 1018, § 2, effective July 1. **L. 2010:** (3)(b)(I)(C), (3)(b)(I)(D), and (3)(b)(II) amended and (3)(b)(I)(E) added, (SB 10-049), ch. 15, p. 75, § 1, effective March 5. **L. 2013:** (2)(a), IP(2)(b), (2)(b)(I), (2)(b)(II), (2)(b)(III), IP(2)(b)(IV), (2)(b)(IV)(A), (2)(b)(V), (2)(b)(XIV), (3), and (4) amended, (2)(b)(XI), (2)(b)(XIII), and (2)(b)(XV) repealed, and (2)(b)(XVI) to (2)(b)(XIX) added (SB 13-032), ch. 34, p. 83, § 2, effective March 15; (2)(b)(X) amended, (HB 13-1266), ch. 217, p. 990, § 56, effective May 13. **L. 2023:** IP(1), IP(1)(a), (1)(a)(II)(A), (1)(a)(II)(B), (1)(b), (1.5), (1.7), (2)(a), IP(2)(b), (2)(b)(XII), (2)(b)(XVI), IP(2)(b)(XVIII), (2)(b)(XVIII)(B), (2)(b)(XVIII)(C), IP(3), (3)(a), IP(3)(b)(I), (3)(b)(I)(B), (3)(b)(II)(A), and (4) amended and (2)(b)(XX), (2)(c), and (3.5) added, (HB 23-1303), ch. 195, p. 981, § 5, effective May 15.

10-20-105. Construction. This article shall be construed to effect the purpose set forth in section 10-20-102, which shall constitute an aid and guide to interpretation.

Source: L. 91: Entire article added, p. 1261, § 1, effective July 1.

10-20-106. Creation of the association. (1) There is hereby created a private nonprofit legal entity to be known as the life and health insurance protection association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance or health maintenance organization business in this state. The association shall perform its functions pursuant to the plan of operation specified in section 10-20-110 and shall exercise its powers through the board of directors provided in section 10-20-107. For purposes of administration and assessment, the association shall maintain three accounts:

(a) The life insurance account;

(b) The health insurance account; and

(c) The annuity account.

(2) The association is under the supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public consistent with the provisions of the insurance laws of Colorado upon majority vote of the board.

Source: L. 91: Entire article added, p. 1261, § 1, effective July 1. **L. 2013:** (2) amended, (SB 13-032), ch. 34, p. 87, § 3, effective March 15. **L. 2023:** IP(1) amended, (HB 23-1303), ch. 195, p. 984, § 6, effective May 15.

10-20-107. Board of directors. (1) The board of directors of the association consists of no fewer than seven nor more than eleven member insurers serving terms as established in the plan of operation. Member insurers shall select members of the board, subject to the approval of

the commissioner. If a vacancy occurs, the remaining board members shall fill the vacancy for the remaining period of the term by a majority vote, subject to the approval of the commissioner. To select the first board and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. At the organizational meeting, each member insurer is entitled to one vote in person or by proxy. If the board is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.

(2) In approving selections or in appointing members to the board, the commissioner shall ensure that all member insurers are fairly represented between member insurers that write primarily life insurance or annuity contracts and member insurers that write primarily health benefit plans. The commissioner shall also consider whether member insurers with experience in providing large group health benefit plans to employers whose employees are subject to a collective bargaining agreement are represented on the board.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board, but members of the board shall not otherwise be compensated by the association for their services.

Source: L. 91: Entire article added, p. 1262, § 1, effective July 1. **L. 2023:** (1) and (2) amended, (HB 23-1303), ch. 195, p. 984, § 7, effective May 15.

10-20-108. Powers and duties of the association. (1) If a member insurer is an impaired insurer, the association may, in its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(a) Guarantee, assume, reissue, or reinsure or cause to be guaranteed, assumed, reissued, or reinsured any or all of the policies or contracts of the impaired insurer; or

(b) Provide such moneys, pledges, loans, notes, guarantees, or other means as proper to effectuate paragraph (a) of this subsection (1) and assure payment of the contractual obligations of the impaired insurer pending action under said paragraph (a).

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a) Guarantee, assume, reissue, or reinsure or cause to be guaranteed, assumed, reissued, or reinsured the covered policies or contracts of the insolvent insurer and provide such money, pledges, notes, guarantees, or other means as are reasonably necessary to discharge those duties; or

(b) Assure payment of the contractual obligations of the insolvent insurer to the residents and provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge those duties; or

(c) Provide benefits and coverages in accordance with the following provisions:

(I) With respect only to life insurance, health insurance, health benefit plans, and annuities, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

(A) With respect to group policies and contracts, not later than the earlier of the next renewal date under the policies or contracts or forty-five days, but in no event less than thirty

days, after the date on which the association becomes obligated with respect to the policies or contracts;

(B) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than thirty days, after the date on which the association becomes obligated with respect to the policies or contracts.

(II) Make diligent efforts to provide to all known insureds, enrollees, or annuitants for nongroup policies and contracts, or to group policy or contract owners with respect to group policies and contracts, thirty days' notice of the termination under subsection (2)(c)(I) of this section of the benefits provided.

(III) With respect to nongroup life insurance, health insurance, health benefit plans, and annuities covered by the association, make available to each known insured, enrollee, or annuitant, or to the owner if other than the insured, enrollee, or annuitant, and with respect to an individual formerly insured or enrolled or formerly an annuitant under a group policy or contract who is not eligible for replacement group coverage, substitute coverage on an individual basis in accordance with subsection (2)(c)(IV) of this section, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right to unilaterally make changes in any provisions of the policy, contract, or annuity or had a right only to make changes in premium by class.

(IV) (A) In providing the substitute coverage required under subsection (2)(c)(III) of this section, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates approved by the commissioner.

(B) The association shall offer alternative or reissued policies or contracts without requiring evidence of insurability, and the policies or contracts must not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.

(C) The association may reinsure any alternative or reissued policy or contract.

(V) (A) Alternative policies or contracts adopted by the association are subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(B) Alternative policies or contracts must contain at least the minimum statutory provisions required in this state and provide benefits reasonably related to the premium charged. The association shall set the premium in accordance with a table of rates that the association adopts. The premium must reflect the amount of insurance or coverage to be provided and the age and class of risk of each insured but must not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

(C) Any alternative policy or contract issued by the association must provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.

(VI) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the association shall set an actuarially justified premium in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to approval by the commissioner.

(VII) The obligations of the association, with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract, cease on the date the coverage, policy, or contract is replaced by another similar policy or contract by the policy owner, insured, enrollee, or association.

(VIII) When proceeding under this subsection (2)(c), with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 10-20-104 (2)(b)(III).

(3) and (4) Repealed.

(5) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the obligations of the association under the policy, contract, or coverage under this article 20 with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with this article 20.

(6) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(6.5) The protection provided by this article does not apply when guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(7) In carrying out its duties under subsection (2) of this section, the association may, subject to approval by a court of competent jurisdiction:

(a) Impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the duties of the association under this article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest;

(b) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts out of the assets of the impaired or insolvent insurer, the association may defer its payment of cash values, policy loans, or other rights of the association for the period of the moratorium or moratorium charge by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(8) If the association fails to act within a reasonable period of time as provided in subsection (2) of this section, the commissioner shall have the powers and duties of the association under this article with respect to insolvent insurers.

(9) There shall be no liability on the part of, and no cause of action shall arise against, the association, or any transferee from the association in connection with the transfer by reinsurance or otherwise of all or any part of an impaired or insolvent insurer's business by

reason of any action taken or any failure to take any action by the impaired or insolvent insurer at any time.

(10) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(11) The association has standing to appear or intervene before any court or agency in this state that has jurisdiction over a member insurer for which the association is or may become obligated under this article 20, or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. The association's standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the member insurer and the determination of the policies or contracts and contractual obligations. The association also has the right to appear or intervene before a court or agency in another state with jurisdiction over a member insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(12) (a) Any person receiving benefits under this article 20 is deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this article 20, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or the provision of substitute or alternative policies, contracts, or coverage. The association may require any payee, policy or contract owner, beneficiary, insured, enrollee, or annuitant to assign the person's rights under, and causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association as a condition precedent to the receipt of any right or benefits conferred by this article 20 upon the person.

(b) The subrogation rights of the association under this subsection (12) have the same priority against the assets of the impaired or insolvent insurer as the rights possessed by the person entitled to receive benefits under this article 20.

(c) In addition to subsections (12)(a) and (12)(b) of this section, the association has all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer, owner, beneficiary, enrollee, or payee of a policy or contract.

(d) If any provision of subsection (12)(a), (12)(b), or (12)(c) of this section is invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations is reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts or portions of the policies or contracts covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in subsections (12)(a) to (12)(d) of this section, the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or portions of policies or contracts, covered by the association.

(13) The association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this article;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments pursuant to section 10-20-109 and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this article 20, and any notes or other evidence of indebtedness of the association not in default are legal investments for domestic member insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this article;

(e) Take such legal action as necessary to avoid payment of improper claims or recover payment of improper claims;

(f) Exercise, for the purposes of this article 20 and to the extent approved by the commissioner, the powers of a domestic life insurer, health insurer, or health maintenance organization, but the association shall not issue policies or contracts other than those issued to perform its obligations under this article 20;

(g) Negotiate and contract with any liquidator or ancillary receiver to carry out the powers and duties of the association;

(g.5) Request information from persons seeking coverage from the association in order to aid the association in determining its obligations under this article with respect to the person; and a person receiving such request shall promptly comply;

(g.7) Take other necessary or appropriate action to exercise its powers and discharge its duties and obligations under this article;

(h) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, elect to succeed to the rights of an insolvent insurer arising after the date of the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making this election, the association shall pay unpaid premiums due with respect to policies covered by the association for coverage relating to periods both before and after the date of the order of liquidation.

(i) File for an actuarially justified rate or premium increase for any policy or contract that it guarantees, assumes, reinsures, reissues, or otherwise provides coverage under this section in accordance with the terms and conditions of the policy or contract and in accordance with other applicable provisions of state law.

(14) The association may join an organization of one or more other state associations of similar purposes to further the purposes and to administer the powers and duties of the association.

(15) Every insured or claimant seeking the protection of this article shall cooperate with the association to the same extent the person or entity would have been required to cooperate with the impaired or insolvent insurer. The association has no cause of action against the insured of the impaired or insolvent insurer for any sums the association has paid out except those causes of action the impaired or insolvent insurer would have had if the sums had been paid by the impaired or insolvent insurer. If an impaired or insolvent insurer operates on a plan with assessment liability, payments of claims by the association do not reduce the liability of the

insured to the receiver, liquidator, rehabilitator, conservator, or statutory successor for unpaid assessments.

(16) The receiver, liquidator, rehabilitator, conservator, or statutory successor of an impaired or insolvent insurer is bound by settlements of covered claims by the association or a similar organization in another state. The association has a claim against the estate of the impaired or insolvent insurer to the extent of claims and expenses paid by the association in connection with the duties of the association as to the impaired or insolvent insurer. The court having jurisdiction shall grant these settled claims in the priority to which the claimant would have been entitled in the absence of this article against the assets of the impaired or insolvent insurer. The expenses, including legal fees of the association or similar organization in handling claims, shall be given the same priority as the expenses of the liquidator, rehabilitator, or conservator.

(17) The association shall periodically file with the liquidator, rehabilitator, or conservator of the impaired or insolvent insurer statements of the covered claims and associated expenses paid by the association and estimates of anticipated claims against the association. This periodic filing preserves the rights of the association for claims against the assets of the impaired or insolvent insurer.

(18) The association shall investigate claims brought against it and adjust, compromise, settle, and pay covered claims to the extent of the obligation of the association and deny all other claims.

(19) A person who has a claim against a member insurer pursuant to a provision of a policy or contract, other than a policy or contract of an impaired or insolvent insurer, that also is a contractual obligation under this article 20, must first exhaust the person's right under that policy or contract. The amount of an approved claim under this article 20 must be reduced by the policy or contract limits of, or amount paid under, that policy or contract, whichever amount is greater. If a claimant exhausts all rights under a policy or contract, other than a policy or contract of an impaired or insolvent insurer, the member insurer issuing that policy or contract is not entitled to sue or continue a suit against the insured of the impaired or insolvent insurer to recover an amount paid to the claimant under the policy or contract; except that a person having a contractual obligation, as defined by this article 20, under a life insurance policy or an annuity contract issued by an impaired or insolvent insurer is not required to exhaust other coverage for that claim, and the amount of an approved claim under a life insurance policy or annuity contract issued by an impaired or insolvent insurer may not be reduced because of that duplicate coverage.

(20) Where the association has arranged or offered to provide the benefits of this article to a covered person under a plan or arrangement that fulfills the association's obligations under this article, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(21) Venue in a suit against the association arising under this article shall be in the city and county of Denver. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this article.

(22) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under this section, the association may issue substitute coverage at actuarially justified rates for a policy or contract that provides for the calculation of returns or changes in value or benefits by the use of an interest rate, crediting rate, or similar factor

determined by use of an index or other external reference, by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

(b) There is no requirement for the evidence of insurability, a waiting period, or any other exclusion that would not have applied under the replaced policy or contact;

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

(23) The board has discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this article in an economical and efficient manner.

(24) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsection (1) or (2) of this section, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor, determined by use of an index or other external reference stated in the policy or contract, employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Source: L. 91: Entire article added, p. 1262, § 1, effective July 1. **L. 94:** IP(3)(a) and (4) amended, p. 1650, § 93, effective May 31. **L. 2000:** (10), (11), (12)(a), and (12)(c) amended and (13)(g.5), (13)(g.7), (20), (21), and (22) added, p. 1020, §§ 3, 4, effective July 1. **L. 2002:** (13)(h) amended, p. 122, § 1, effective March 26. **L. 2013:** (1), (2), IP(7), (7)(b), (8), (9), (10), (12)(b), (12)(c), (13)(e), (15), (16), (17), and (19) amended, (3) and (4) repealed, and (6.5), (12)(d), (12)(e), (23), and (24) added, (SB 13-032), ch. 34, p. 87, § 4, effective March 15. **L. 2023:** (1)(a), (2)(a), (2)(c), (5), (6), (11), (12), (13)(c), (13)(f), (19), IP(22), and IP(24) amended and (13)(i) added, (HB 23-1303), ch. 195, p. 984, § 8, effective May 15.

10-20-109. Assessments. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess each member insurer separately for each account at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at the rate set forth in 28 U.S.C. sec. 1961 on and after the due date.

(2) The board shall impose two assessments, as follows:

(a) Class A assessments must be authorized and called for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of section 10-20-115; except that the board shall not impose a class A assessment against a member insurer that has not received premiums for a covered policy in the calendar year immediately preceding the calendar year in which the assessment is imposed. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments must be authorized and called to the extent necessary to carry out the powers and duties of the association under section 10-20-108 with regard to an impaired or insolvent insurer.

(3) (a) The amount of any class A assessment must be determined by the board and may be authorized and called on a non-pro rata basis. The amount of any class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion to be fair and reasonable under the circumstances.

(b) (I) The board shall determine class B assessments against member insurers for each account based on the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, bear to the premiums received on business in this state for those calendar years by all assessed member insurers.

(II) Of the amount of class B assessments for long-term care insurance written by the impaired or insolvent insurer, the board shall allocate:

(A) Fifty percent to the health insurance account; except that a member insurer that is a nonprofit health maintenance organization that provides a majority of covered professional services through physicians it employs or through a single contracted medical group shall be assessed as if the board allocated only twenty-five percent to the health insurance account; and

(B) Fifty percent, on a pro rata basis, to the life insurance account and the annuity account; except that, on a pro rata basis, the life insurance account and the annuity account shall cover the shortfall from the health insurance account that results from the lower assessment rate described in subsection (3)(b)(II)(A) of this section on a member insurer that is a nonprofit health maintenance organization that provides a majority of covered professional services through physicians it employs or through a single contracted medical group.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer must not be authorized or called until necessary to implement the purposes of this article. Classification of assessments under subsection (2) of this section and computation of assessments under this subsection (3) shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment

is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(5) (a) Subject to subsection (5)(b) of this section, the total of all assessments authorized by the association with respect to a member insurer for each account must not exceed, in any one calendar year, two percent of the average premiums received by the member insurer in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the member insurer became impaired or insolvent.

(b) If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subsection (5)(a) of this section is equal and limited to the highest of the three-year average annual premiums for the applicable account as calculated under this section.

(c) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any of the accounts an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(d) The board shall provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(6) The board shall, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out, during the coming year, the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. The board shall retain a reasonable amount in each account to provide funds for the continuing expenses of the association and for future losses.

(7) (a) A member insurer, in determining its premium rates and policyholder dividends for any kind of insurance or health maintenance organization business within the scope of this article 20, may consider the amount reasonably necessary to meet its assessment obligations under this article 20.

(b) A member insurer subject to assessments pursuant to subsection (2) of this section shall not cut employment, reduce employee pay or hours, or reduce employment benefits as a result of the assessments levied pursuant to subsection (2) of this section.

(8) The association shall issue to each member insurer paying an assessment for the life and annuity accounts under this article 20, other than a class A assessment, a certificate of contribution from the association, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. The member insurer may show the certificate of contribution in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve; but the member insurer, at its option, has the right in any event to show the certificate of contribution as an admitted asset at percentages of the original face amount of the assessment for calendar years as follows:

(a) One hundred percent for the first year after issuance; and

(b) One hundred percent less any amount already taken as an offset against premium tax liability pursuant to section 10-20-113 for the second and subsequent years after issuance.

(9) Any member insurer whose certificate of authority or license has been terminated for any reason whatsoever is liable for any assessment based on insolvencies arising prior to termination of a member insurer's certificate of authority or license.

(10) (a) A member insurer that intends to protest all or part of an assessment shall pay, when due, the full amount of the assessment in the notice provided by the association. The payment must be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payments must be accompanied by a statement in writing that the payment is made under protest and a brief statement of the grounds for the protest.

(b) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty days after a final decision, the association shall notify the protesting member insurer in writing of the final decision. Within sixty days after receiving notice of the final decision, the protesting member insurer may appeal the final decision to the commissioner.

(d) In alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests directly to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the association must return the amount paid in error or excess to the member insurer. Interest on a refund due to a protesting member insurer must be paid at the rate actually earned by the association.

(11) The association may request information of member insurers in order to aid in the exercise of its power under this section. Member insurers shall promptly reply to any request for information from the association.

Source: L. 91: Entire article added, p. 1269, § 1, effective July 1. **L. 2000:** (8) amended, p. 1022, § 5, effective July 1. **L. 2013:** (2), (3), (5), and (10) amended and (11) added, (SB 13-032), ch. 34, p. 94, § 5, effective March 15. **L. 2023:** IP(2), (2)(a), (3)(b), (5)(a), (5)(b), (6), (7), IP(8), and (9) amended, (HB 23-1303), ch. 195, p. 989, § 9, effective May 15.

10-20-110. Plan of operation - rules. (1) (a) The association shall maintain a plan of operation to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall be submitted to the commissioner and be effective upon the commissioner's written approval or after thirty days if said commissioner has not disapproved.

(b) If the association fails to submit a suitable plan of operation or suitable amendments to the plan within sixty days after May 15, 2023, the commissioner shall, after notice and hearing, adopt and promulgate reasonable rules as necessary or advisable to effectuate this article 20. The rules continue in effect until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation must, in addition to any other provisions specified in this article:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board pursuant to section 10-20-107;

(c) Establish regular places and times for meetings including telephone conference calls of the board;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board;

(e) Establish the procedures whereby selections for the board will be made and submitted to the commissioner;

(f) Establish any additional procedures for assessments under section 10-20-109;

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association;

(h) Establish procedures whereby a director may be removed for cause, including a director or member insurer that becomes an impaired or insolvent insurer;

(i) Require the board of directors to establish a policy and procedures to address conflicts of interest.

(4) The plan of operation may provide that any or all powers and duties of the association, except those established pursuant to sections 10-20-108 (13)(c) and 10-20-109, are delegated to a corporation, association, or other organization that performs, or will perform, functions similar to those of the association established pursuant to this article 20 or its equivalent in two or more states. The association shall reimburse a corporation, association, or organization to which the association has delegated its powers and duties for any payments made on behalf of the association and shall pay the corporation, association, or organization for its performance of any association function. A delegation pursuant to this subsection (4) takes effect only with the approval of both the board and the commissioner, and the association may delegate its powers and duties only to a corporation, association, or organization that extends protection not substantially less favorable and effective than the protection provided by this article 20.

(5) Repealed.

Source: L. 91: Entire article added, p. 1272, § 1, effective July 1. **L. 2013:** IP(3) amended, (3)(h) and (3)(i) added, and (5) repealed, (SB 13-032), ch. 34, p. 96, § 6, effective March 15. **L. 2023:** (1)(b) and (4) amended, (HB 23-1303), ch. 195, p. 991, § 10, effective May 15.

10-20-111. Powers and duties of the commissioner. (1) In addition to any other powers and duties specified in this article 20, the commissioner shall:

(a) Upon request of the board, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

(b) Notify the board of the existence of an impaired or insolvent insurer not later than three days after a determination of impairment or insolvency is made by the commissioner, irrespective of limitations imposed upon the commissioner in section 10-3-401;

(c) In any liquidation proceeding involving a domestic member insurer, be appointed as the liquidator.

(2) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority or license to transact insurance or the business of a health maintenance organization in this state of any member insurer that fails to pay an assessment when due or fails to comply with

the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture must not exceed five percent of the unpaid assessment per month, but a forfeiture must not be less than one hundred dollars per month.

(3) The conservator, rehabilitator, or liquidator of any impaired or insolvent insurer shall notify all interested persons of the effect of this article.

Source: L. 91: Entire article added, p. 1274, § 1, effective July 1. **L. 2013:** (1)(b) and (3) amended, (SB 13-032), ch. 34, p. 97, § 7, effective March 15. **L. 2023:** IP(1), (1)(c), and (2) amended, (HB 23-1303), ch. 195, p. 991, § 11, effective May 15.

10-20-112. Prevention of insolvencies. (1) To aid in the detection and prevention of member insurer insolvencies, it is the duty of the commissioner:

(a) To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when action is taken in any of the following matters against a member insurer:

(I) Revocation of license;

(II) Suspension of license; or

(III) Issuance of a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of owners, certificate holders, enrollees, or creditors. The commissioner shall mail the notice to all commissioners within thirty days following the action taken or the date on which the action occurs.

(b) To report to the board when the commissioner has taken any of the actions set forth in paragraph (a) of this subsection (1) or has received a report from any other commissioner indicating that such action has been taken in another state. Such report to the board shall contain all significant details of the action taken or the report received from another commissioner.

(c) To report to the board when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the member insurer may be an impaired or insolvent insurer;

(d) To furnish to the board the NAIC insurance regulatory information system ratios and listings of companies not included in the ratios developed by the NAIC, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein shall be kept confidential by the board until such time as made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance or health maintenance organization business in this state.

(3) Upon the commissioner's request, the board shall report and make recommendations to the commissioner upon any matter germane to the solvency or liquidation of any member insurer or germane to the solvency of any company seeking to do insurance or health maintenance organization business in this state. The reports and recommendations are not public documents.

(4) The board of directors may, upon a majority vote, notify the commissioner of any information indicating that a member insurer may be impaired or insolvent.

(5) Repealed.

(6) The board may make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

(7) Repealed.

Source: L. 91: Entire article added, p. 1274, § 1, effective July 1. **L. 2000:** (3), (4), (5), (6), and (7) amended, p. 1023, § 6, effective July 1. **L. 2013:** (1)(c) and (4) amended and (5) and (7) repealed, (SB 13-032), ch. 34, p. 97, § 8, effective March 15. **L. 2023:** IP(1), (1)(a)(III), (1)(c), (2), (3), and (6) amended, (HB 23-1303), ch. 195, p. 992, § 12, effective May 15.

10-20-113. Credits for assessments paid - tax offsets. (1) (a) A member insurer may offset against its premium tax liability to this state that amount of its class B assessment described in section 10-20-109 that was assessed for the association's life and annuity accounts pursuant to section 10-20-106 to the extent of twenty percent of the amount of such assessment for each of the first, second, third, fourth, and fifth calendar years following the year in which such assessment was paid.

(b) To the extent the offsets specified in paragraph (a) of this subsection (1) exceed the member insurer's premium tax liability, they may be carried forward to offset premium tax liabilities in future years. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(c) In no event shall the total amount of all such offsets for all member insurers exceed four million dollars in any year. The association shall prorate the amount of such offset among all member insurers if the total amount of offset would otherwise exceed four million dollars in any such year and shall notify each insurer of the maximum amount of offset allowable for that year and the amount of the excess offset, if any, that may be carried forward to future years.

(d) (I) Each member insurer writing health insurance or health maintenance organization policies or contracts may recoup over a reasonable length of time a sum reasonably calculated to recoup the assessments paid by the member insurer under this article 20 by imposing a surcharge on premiums charged for health insurance or health maintenance organization policies or contracts to which this article 20 applies. Amounts recouped are not premiums for any other purpose, including the computation of gross premium tax or an agent's commission.

(II) A member insurer that imposes a surcharge under subsection (1)(d)(I) of this section shall include the amount of the surcharge as part of the member insurer's rate filing pursuant to section 10-16-107 (1). The member insurer must show the surcharge in the rate filing as a separate component of the rate and shall include supporting documentation.

(III) A member insurer that collects surcharges in excess of assessments paid pursuant to this article 20 for an insolvent insurer shall remit the excess to the association as an additional assessment within one hundred twenty days after the end of the collection period as determined by the association. The association shall apply the excess amount to reduce future assessments for that member insurer in the appropriate category.

(IV) (Deleted by amendment, L. 2023.)

(2) Any sums which are acquired by refund pursuant to section 10-20-109 (6) from the association by member insurers, and which have theretofore been offset against premium taxes as provided in subsection (1) of this section, shall be paid by such insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such payments have been made.

(3) (a) The purpose of the credit authorized in subsection (1)(a) of this section is to offset the cost for an insurer paying required assessments into the life and health insurance protection association created in section 10-20-106 (1).

(b) The effectiveness of the credit authorized in subsection (1)(a) of this section is measured by how many eligible insurers claim the credit and the amount claimed relative to payments into the life and health insurance protection association created in section 10-20-106 (1).

Source: L. 91: Entire article added, p. 1276, § 1, effective July 1. **L. 92:** (1)(d)(II) amended, p. 1726, § 12, effective July 1. **L. 2000:** (1)(a) and (1)(c) amended, p. 1023, § 7, effective July 1. **L. 2023:** (1)(d) amended, (HB 23-1303), ch. 195, p. 992, § 13, effective May 15. **L. 2025:** (3) added, (SB 25-026), ch. 362, p. 1964, § 4, effective August 6.

10-20-114. Miscellaneous provisions - definition. (1) Nothing in this article 20 reduces the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) The association must keep records of all meetings of the board to discuss the activities of the association in carrying out its powers and duties pursuant to section 10-20-108. Records of the meetings may be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the member insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection (2) limits the duty of the association to render a report of its activities under section 10-20-115.

(3) For the purpose of carrying out its obligations under this article 20, the association is deemed a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies and covered contracts, reduced by any amounts to which the association is entitled as assignee or subrogee pursuant to section 10-20-108 (12). Assets of the impaired or insolvent insurer attributable to covered policies and covered contracts shall be used to continue all covered policies and covered contracts and pay all contractual obligations of the impaired or insolvent insurer as required by this article 20. "Assets of the impaired or insolvent insurer attributable to covered policies and covered contracts", as used in this subsection (3), means that proportion of the assets that the reserves that should have been established for the policies or contracts bear to the reserves that should have been established for all policies or contracts written by the impaired or insolvent insurer.

(3.5) As a creditor of an impaired or insolvent insurer as established in this section and consistent with section 10-3-533, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets from time to time as the assets become available to reimburse the association, as a credit against contractual obligations under this article 20. If the liquidator has not made an application to the receivership court for approval of a proposal to disburse assets out of marshaled assets to guaranty associations having

obligations because of the insolvency within one hundred twenty days after a final determination of insolvency of a member insurer by the receivership court, the association may apply to the receivership court for approval of its own proposal to disburse these assets.

(4) (a) Prior to the termination of any rehabilitation, conservation, or liquidation proceeding, the court may take into consideration the contributions of the respective parties, including the association, shareholders, owners, certificate holders, or enrollees of the impaired or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In making a determination under this subsection (4)(a), the court shall consider the welfare of the owners, certificate holders, or enrollees of the continuing or successor member insurer.

(b) A distribution shall not be made to stockholders, if any, of an impaired or insolvent insurer until the total amount of valid claims of the association for reimbursement, including interest, of funds expended in carrying out its powers and duties pursuant to section 10-20-108 with respect to the impaired or insolvent insurer have been fully recovered by the association.

(5) (a) If an order for rehabilitation or liquidation of a member insurer domiciled in this state has been entered, the receiver appointed under the order has a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation, subject to the limitations of subsections (5)(b) to (5)(d) of this section.

(b) A distribution described in subsection (5)(a) of this section is not recoverable if the member insurer shows that the distribution, when it was paid, was lawful and reasonable and that the member insurer did not know, and could not reasonably have known, that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid is liable up to the amount of distributions the person received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared is liable up to the amount of the distributions the person would have received if the distributions had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this subsection (5) is the amount needed, in excess of all other available assets of the impaired or insolvent insurer, to pay the contractual obligations of the impaired or insolvent insurer.

(e) If any person liable pursuant to subsection (5)(c) of this section is insolvent, all of its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(6) Nothing in this article 20 imposes any liability or responsibility on the state of Colorado for the obligations of the life and health insurance protection association or the unpaid claims of impaired or insolvent insurers.

Source: L. 91: Entire article added, p. 1278, § 1, effective July 1. **L. 2013:** (1), (2), (3), (4), (5)(a), and (5)(d) amended and (3.5) added, (SB 13-032), ch. 34, p. 98, § 9, effective March 15. **L. 2023:** Entire section amended, (HB 23-1303), ch. 195, p. 993, § 14, effective May 15.

10-20-115. Examination of the association - annual report. The association shall be subject to examination and regulation by the commissioner. The board shall submit to the commissioner each year, not later than one hundred twenty days after the close of the fiscal year of the association, a financial report in a form approved by the commissioner, and a report of the activities of the board during the preceding fiscal year.

Source: L. 91: Entire article added, p. 1280, § 1, effective July 1.

10-20-116. Tax exemptions. The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real and personal property.

Source: L. 91: Entire article added, p. 1280, § 1, effective July 1.

10-20-117. Immunity. There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, its agents, or its employees, the association, its agents, or its employees, members of the board or the commissioner or his representatives for any action or omission by them in the performance of their powers and duties pursuant to this article. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

Source: L. 91: Entire article added, p. 1280, § 1, effective July 1.

10-20-118. Stay of proceedings - reopening default judgments. All proceedings in which the impaired or insolvent insurer is a party in any court in this state shall be stayed for one hundred eighty days after the date an order of conservation, rehabilitation, or liquidation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that issued the judgment and shall be permitted to defend against such suit on the merits.

Source: L. 91: Entire article added, p. 1280, § 1, effective July 1. **L. 2013:** Entire section amended, (SB 13-032), ch. 34, p. 99, § 10, effective March 15.

10-20-119. Prohibited advertisement of association article in insurance sales - notice to owners, certificate holders, and enrollees. (1) A person, including a member insurer and any agent or affiliate of a member insurer, shall not make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, that uses the existence of the life and health insurance protection association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this article 20. However, this section does not apply to the association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

(2) The association shall prepare a summary document, in compliance with subsection (3) of this section, describing the general purposes and current limitations of this article 20. The association shall submit the summary document to the commissioner for approval. Sixty days after receiving approval from the commissioner, each member insurer, when delivering a policy or contract as described in section 10-20-104 (2)(a) to an owner, a certificate holder, or an enrollee, shall deliver the summary document concurrently with or before delivering the policy or contract unless subsection (4) of this section applies. The member insurer shall also make the summary document available upon request by an owner, a certificate holder, or an enrollee. The distribution, delivery, or contents or interpretation of the summary document does not mean that either the policy or the contract or the owner, certificate holder, or enrollee will be covered in the event of impairment or insolvency of a member insurer. The association shall revise the summary document as necessary based on amendments to this article 20 or as other circumstances may require. Failure to receive this summary document does not give an owner, a certificate holder, an insured, or an enrollee any rights other than those stated in this article 20.

(3) The summary document prepared pursuant to subsection (2) of this section must contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer must:

(a) State the name and address of the association and the division of insurance;

(b) Prominently warn the owner, certificate holder, or enrollee that the association may not cover the policy or contract or, if coverage is available, the policy or contract may be subject to substantial limitations and exclusions and is conditioned on the continued residence in the state by the owner, insured, certificate holder, or enrollee;

(c) State that the member insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage;

(d) Emphasize that the owner, certificate holder, or enrollee should not rely on coverage by the association when selecting a member insurer; and

(e) Provide other information as directed by the commissioner.

(4) A member insurer or agent of a member insurer shall not deliver a policy or contract that is described in section 10-20-104 (2)(a) but excluded under section 10-20-104 (2)(b)(I) from coverage under this article 20 unless the member insurer or agent, before or at the time of delivery, gives the owner, certificate holder, or enrollee a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the association. The commissioner shall specify the form and content of the notice.

Source: L. 91: Entire article added, p. 1280, § 1, effective July 1. **L. 2023:** Entire section amended, (HB 23-1303), ch. 195, p. 995, § 15, effective May 15.

10-20-120. Prospective application. This article 20, as amended, does not apply to any member insurer that is declared insolvent on or before May 15, 2023.

Source: L. 91: Entire article added, p. 1282, § 1, effective July 1. **L. 2023:** Entire section amended, (HB 23-1303), ch. 195, p. 996, § 16, effective May 15.

HEALTH CARE

Cross references: For the "Colorado Health Care Coverage Act", see article 16 of this title.

ARTICLE 21

The Colorado Care Health Insurance Program

10-21-101 to 10-21-106. (Repealed)

Source: L. 2004: Entire article repealed, p. 1011, § 23, effective August 4.

Editor's note: This article was added in 1992. For amendments to this article prior to its repeal in 2004, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 22

Colorado Health Benefit Exchange

10-22-101. Short title. This article is known and may be cited as the "Colorado Health Benefit Exchange Act".

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1073, § 1, effective June 1.

10-22-102. Legislative declaration - intent. The general assembly determines and declares that with the March 23, 2010, enactment of the federal "Patient Protection and Affordable Care Act", Pub.L. 111-148, and the March 30, 2010, enactment of the "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152, which allow each state to establish a health benefit exchange through state law or opt to participate in a national health benefit exchange operated by the federal department of health and human services, and although there are numerous federal lawsuits challenging the constitutionality of the federal act in multiple federal courts, the best option for the state of Colorado is to establish a health benefit exchange at the state level. The general assembly further finds that the federal act requires each state to establish a health benefit exchange to perform certain duties and to assume certain responsibilities set forth in the federal act or make sufficient progress in the creation of a health benefit exchange by January 1, 2013, or default to a federally run national health benefit exchange. Therefore, the general assembly intends to create a health benefit exchange to fit the unique needs of Colorado, seek Colorado-specific solutions, and explore the maximum number of options available to the state of Colorado. The Colorado health benefit exchange, including an American health benefit exchange, is intended to facilitate the access to and enrollment in health plans in the individual market in this state and include a small business health options program to assist small employers in this state in facilitating the enrollment of their employees in health

plans offered in the small employer market. The intent of the Colorado health benefit exchange is to increase access, affordability, and choice for individuals and small employers purchasing health insurance in Colorado.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1073, § 1, effective June 1.

10-22-103. Definitions. As used in this article 22, unless the context otherwise requires:

(1) "Board" means the board of directors of the exchange, appointed in accordance with section 10-22-105.

(2) "Committee" means the Colorado health insurance exchange oversight committee created in section 10-22-107.

(3) "Exchange" means the Colorado health benefit exchange created in this article.

(4) "Federal act" means the "Patient Protection and Affordable Care Act", Pub.L. 111-148, as amended by the "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152.

(5) "Group health plan" means an employee welfare benefit plan as defined in 29 U.S.C. sec. 1002 (1) of the federal "Employee Retirement Income Security Act of 1974" to the extent that the plan provides health-care services, including items and services paid for as health-care services, to employees or their dependents directly or through insurance reimbursement or otherwise. A "group health plan" includes a government or church plan.

(6) "Health benefit plan" has the same meaning set forth in section 10-16-102; except that the term includes a dental plan.

(6.5) "Health-care coverage affordability program" means:

(a) A medical assistance program under the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5;

(b) The "Children's Basic Health Plan Act", article 8 of title 25.5; or

(c) A health benefit plan offered through the exchange for which a premium tax credit or cost-sharing reductions are available.

(7) "Insurer" means any entity that provides group health plans or individual health benefit plans subject to insurance regulation in this state, as well as any entity that directly or indirectly provides stop-loss or excess loss insurance to a self-insured group health plan including a property and casualty insurance company.

(8) "Medicaid" means federal insurance or assistance as provided by Title XIX of the federal "Social Security Act", as amended.

(9) "Medicare" means federal insurance or assistance as provided by Title XVIII of the federal "Social Security Act", as amended.

(10) "Number of lives insured" means the number of employees and retired employees and individual policyholders or subscribers in the individual and group markets on March 1 of the previous calendar year for which a special fee is being assessed. For insurers providing stop-loss, excess loss, or reinsurance, "number of lives insured" does not include employees, retired employees, or individual policyholders or subscribers who have been counted by the primary insurer or primary reinsurer.

(11) "Secretary" means the secretary of the United States department of health and human services.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1074, § 1, effective June 1. **L. 2013:** (5) amended and (6) to (11) added, (HB 13-1245), ch. 258, p. 1359, § 1, effective May 23. **L. 2015:** (2) amended, (SB 15-256), ch. 284, p. 1166, § 1, effective June 5. **L. 2020:** IP amended and (6.5) added, (HB 20-1236), ch. 236, p. 1144, § 2, effective September 14.

10-22-104. Health benefit exchange - creation. There is hereby created a nonprofit unincorporated public entity known as the health benefit exchange. The board of directors shall govern the operation of the exchange. The board shall determine and establish the development, governance, and operation of the exchange. The exchange is an instrumentality of the state; except that the debts and liabilities of the exchange do not constitute the debts and liabilities of the state, and neither the exchange nor the board is an agency of the state. The board does not have the authority to promulgate rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S. The exchange shall not duplicate or replace the duties of the commissioner established in section 10-1-108, including rate approval, except as directed by the federal act. The exchange shall foster a competitive marketplace for insurance and shall not solicit bids or engage in the active purchasing of insurance. All carriers authorized to conduct business in this state may be eligible to participate in the exchange.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1074, § 1, effective June 1.

10-22-105. Exchange board of directors. (1) (a) There is created the board of directors of the exchange. The board consists of twelve members, including nine voting members appointed pursuant to subsection (1)(b) of this section and three nonvoting, ex officio members as set forth in subsection (1)(c) of this section.

(b) (I) The governor shall appoint five voting members to the board, and the president of the senate, the minority leader of the senate, the speaker of the house of representatives, and the minority leader of the house of representatives shall each appoint one voting member to the board. The governor shall not appoint more than three members from the same political party.

(II) Appointed members of the board may be removed by their respective appointing authorities for cause. The appointing authority making the original appointment shall fill a vacancy by appointment for the remainder of an unexpired term.

(III) The term of an appointed member is four years; except that the terms shall be staggered so that no more than five members' terms expire in the same year. Members may serve a maximum of two consecutive terms. If a member is appointed to fill a vacancy and serves for more than half of the unexpired term, the member shall be eligible for appointment to only one more consecutive term.

(IV) The appointing authorities shall coordinate appointments to ensure that there is broad representation within the skill sets specified in this subsection (1)(b)(IV) and shall consider the geographic, economic, ethnic, and other characteristics of the state when making the appointments. A majority of the voting members must be business representatives or individuals who are not directly affiliated with the insurance industry, and none shall be state employees. Each person appointed to the board should have demonstrated expertise in at least two, and in any case shall have demonstrated expertise in no less than one, of the following areas:

(A) Individual health insurance coverage;

(B) Small employer health insurance;
(C) Health benefits administration;
(D) Health-care finance;
(E) Administration of a public or private health-care delivery system;
(F) The provision of health-care services;
(G) The purchase of health insurance coverage;
(H) Health-care consumer navigation or assistance;
(I) Health-care economics or health-care actuarial sciences;
(J) Information technology; or
(K) Starting a small business with fifty or fewer employees.

(c) The executive director of the department of health care policy and financing, or his or her designee; the commissioner of insurance, or his or her designee; and the director of the office of economic development and international trade, or his or her designee, shall serve as nonvoting, ex officio members of the board.

(d) The board shall elect one of its members as chair of the board.

(2) Each member of the board is responsible for meeting the requirements of this article and all applicable state and federal laws, rules, and regulations; serving in the public interest of the individuals and small businesses seeking health-care coverage through the exchange; and ensuring the operational well-being and fiscal solvency of the exchange.

(3) (a) Board members shall not receive compensation for performance of services for the board but may receive a per diem and reimbursement for travel and other necessary expenses while engaged in the performance of official duties of the board. Per diem and reimbursement expenses are paid through grant moneys received by the board.

(b) A member of the board shall not perform an official act that may have a direct economic benefit on a business or other undertaking in which the member has a direct or substantial financial interest.

(c) A board member or an officer or employee of the exchange is not liable for an act or omission when acting in his or her official capacity, in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this article.

(4) (a) Board members are subject to articles 6, 18, and 72 of title 24, C.R.S.

(b) All moneys received by the board for the exchange are subject to audit by the legislative audit committee. The board shall report all moneys received for the exchange to the legislative audit committee.

(c) The state auditor may conduct or cause to be conducted a performance audit of the exchange, including the operation, contract management, project management, and performance of the shared eligibility system and any other related or corresponding state systems in order to ensure a complete and thorough audit of the operation of the exchange. Upon completion of a performance audit, the state auditor shall submit a written report to the legislative audit committee, together with any findings and recommendations. The state auditor has continuing authority to conduct performance audits of the exchange whenever the state auditor or the legislative audit committee deems appropriate.

(5) Any information provided to a board member pursuant to this article that is exempt from disclosure under either section 24-72-204, C.R.S., or part 4 of article 6 of title 24, C.R.S., shall be and remain confidential and may be used only by the board.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1075, § 1, effective June 1. **L. 2015:** (4)(c) added, (SB 15-019), ch. 69, p. 187, § 1, effective April 3. **L. 2022:** (1) amended, (SB 22-013), ch. 2, p. 7, § 7, effective February 25.

10-22-106. Powers and duties of the board. (1) The board is the governing body of the exchange and has all the powers and duties necessary to implement this article 22. The board shall:

(a) Appoint an executive director to administer the exchange, subject to approval by the committee;

(b) Create an initial operational and financial plan, subject to approval by the committee;

(c) Apply for planning and establishment grants made available to the exchange pursuant to the federal act and apply for, receive, and expend other gifts, grants, and donations. Each grant application is subject to the review and unanimous approval of the board chair and the chair and vice-chair of the committee prior to the submission of the application. If there is not unanimous approval, each grant application is subject to review and the majority approval of the committee.

(d) Create technical and advisory groups to operate on an ongoing basis and to report to the board and provide guidance at the direction of the board on issues that directly or indirectly affect consumers. The board shall use reasonable efforts to ensure that the technical and advisory groups reflect geographic diversity and diverse opinions on issues affecting consumers. The technical and advisory groups shall meet as necessary to discuss issues related to the exchange and to make recommendations to the board.

(e) Provide a written open enrollment report to the governor and the general assembly annually and present an open enrollment update to the senate health and human services committee and the house of representatives health and human services committee, or their successor committees, during each legislative session;

(f) Review the internet portal operated and maintained by the secretary and the model template for an internet portal made available by the secretary for use by the state exchanges and review other appropriate internet portals. The review must include an examination as to whether the model template may be used to direct individuals and employers to health plans, to assist individuals and employers in determining whether they are eligible to participate in the exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information regarding health plans offered through the exchange to assist consumers in making health insurance choices.

(g) Consider the desirability of structuring the exchange as one entity that includes two underlying entities to operate in the individual and the small employer markets, respectively;

(h) Consider the appropriate size of the small employer market under the exchange, taking into consideration the definition of "small employer" pursuant to section 10-16-102;

(i) Consider the unique needs of rural Coloradans as they pertain to access, affordability, and choice in purchasing health insurance;

(j) Consider the affordability and cost in the context of quality care and increased access to purchasing health insurance; and

(k) Investigate requirements, develop options, and determine waivers, if appropriate, to ensure that the best interests of Coloradans are protected.

(2) The board may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this article so long as

the agreements include adequate protections with respect to the confidentiality of the information that is shared and comply with all state and federal laws, rules, and regulations.

(3) The board may create a separate program that shares resources and infrastructure with the exchange to offer ancillary products.

(4) The board may enter into an agreement with the department of personnel to authorize administrative law judges employed by the office of administrative courts to hear and decide matters arising from eligibility and other determinations made by the exchange consistent with applicable state and federal law.

(5) (a) The board, with public input, shall set a policy that makes clear which actions by the exchange require public scrutiny and shall make the policy available to the committee. In determining which actions require public scrutiny, the board shall consider the effects the exchange's actions have on consumers.

(b) Prior to taking an action that requires public scrutiny, the exchange shall post notice of the planned action on the exchange website at least three weeks prior to the date of the board meeting at which the action will be discussed. The exchange shall provide time for public comments and questions at the board meeting and post the final action on the exchange website.

(c) The board may adopt an action without compliance with paragraph (b) of this subsection (5) if the board finds that immediate adoption is necessary to avoid disruption of the continuing operation of the exchange. The exchange shall make the action and the reasons for the action available to the public and the committee.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1076, § 1, effective June 1. **L. 2013:** (3) and (4) added, (HB 13-1245), ch. 258, p. 1360, § 2, effective May 23. **L. 2014:** (4) amended, (HB 14-1363), ch. 302, p. 1262, § 5, effective May 31. **L. 2016:** (1)(d) amended and (5) added, (HB 16-1148), ch. 40, p. 99, § 1, effective June 1. **L. 2024:** IP(1), (1)(d), and (1)(e) amended, (HB 24-1035), ch. 44, p. 158, § 1, effective August 7.

10-22-107. Colorado health insurance exchange oversight committee - creation - duties - repeal. (1) (a) For the purposes of guiding implementation of an exchange in Colorado, making recommendations to the general assembly, and ensuring that the interests of Coloradans are protected and furthered, there is hereby created the Colorado health insurance exchange oversight committee. The committee shall meet at the call of the chair at least one time during each calendar year when the general assembly is not in session but no more than seven times during each calendar year when the general assembly is not in session. The committee may meet an unlimited number of times at the call of the chair when the general assembly is in session. The committee may use the legislative council staff to assist its members in researching any matters.

(b) Repealed.

(c) (I) Notwithstanding subsection (1)(a) of this section, the committee shall not meet during the 2025 interim.

(II) This subsection (1)(c) is repealed, effective July 1, 2026.

(2) (a) The president of the senate shall appoint three members to the committee. Two appointees must be members of the senate health and human services committee; the senate business, labor, and technology committee; the legislative audit committee; or their successor committees. One appointee must be a representative of the senate at large.

(b) The speaker of the house of representatives shall appoint three members to the committee. Two appointees must be members of the house of representatives health and human services committee, the house of representatives business affairs and labor committee, the legislative audit committee, or their successor committees. One appointee must be a representative of the house of representatives at large.

(c) The minority leader of the senate shall appoint two members to the committee. One appointee must be a member of the senate health and human services committee; the senate business, labor, and technology committee; the legislative audit committee; or their successor committees. One appointee must be a representative of the senate at large.

(d) The minority leader of the house of representatives shall appoint two members to the committee. One appointee must be a member of the house of representatives health and human services committee, the house of representatives business affairs and labor committee, the legislative audit committee, or their successor committees. One appointee must be a representative of the house of representatives at large.

(e) Members of the committee shall serve at the pleasure of the appointing authority.

(3) Members of the committee shall serve without compensation; except that each member shall receive the sums specified in section 2-2-307 (3)(a) and (3)(b), C.R.S., for attendance at meetings of the committee when the general assembly is in recess for more than three days or is not in session.

(4) During odd-numbered years, the president of the senate shall appoint the chair, and the speaker of the house of representatives shall appoint the vice-chair of the committee. During even-numbered years, the speaker of the house of representatives shall appoint the chair, and the president of the senate shall appoint the vice-chair of the committee.

(5) (a) In any year, the committee may report up to eight bills or other measures to the legislative council created in section 2-3-301. These bills are exempt from any applicable bill limit imposed on the individual committee members sponsoring such bills if the bills have been approved by the legislative council under joint rules of the senate and house of representatives.

(b) Repealed.

(c) (I) Notwithstanding subsection (5)(a) of this section, the committee shall not report to the legislative council and shall not recommend legislation during the 2025 interim.

(II) This subsection (5)(c) is repealed, effective July 1, 2026.

(6) The committee shall review grants applied for by the board to implement the exchange.

(7) The exchange shall annually present to the committee the financial and operational plans of the exchange and the major actions taken by the board, particularly actions that affect consumers. The committee shall review the financial and operational plans of the exchange and the major actions taken by the board.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1078, § 1, effective June 1. **L. 2013:** (1) and (7) amended, (HB 13-1245), ch. 258, p. 1360, § 3, effective May 23. **L. 2015:** (1) and (5) amended, (SB 15-256), ch. 284, p. 1166, § 2, effective June 5. **L. 2016:** (7) amended, (HB 16-1148), ch. 40, p. 100, § 2, effective June 1. **L. 2020:** (1) and (5) amended, (SB 20-214), ch. 200, p. 981, § 7, effective June 30. **L. 2024:** (1)(a), (2), and (7) amended, (HB 24-1035), ch. 44, p. 159, § 2, effective August 7. **L. 2025:** (1)(c) and (5)(c) added, (SB 25-199), ch. 149, p. 567, § 6, effective April 30.

Editor's note: Subsections (1)(b)(II) and (5)(b)(II) provided for the repeal of subsections (1)(b) and (5)(b) respectively, effective July 1, 2021. (See L. 2020, p. 981.)

10-22-108. Moneys for implementation, operation, and sustainability of the exchange. Moneys received by the board for the implementation of this article, and for building reserves for the operation and sustainability of the exchange pursuant to section 10-22-109, must be transferred directly to the exchange for the purposes of this article. The board shall deposit any moneys received in a banking institution within or outside the state. Moneys from the general fund shall not be used for the implementation of this article, except for the sums specified in section 10-22-107 (3) and for legislative staff agency services. The account of the banking institution must be insured by the federal deposit insurance corporation and compliant with the "Public Deposit Protection Act", article 10.5 of title 11, C.R.S.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1079, § 1, effective June 1. **L. 2013:** Entire section amended, (HB 13-1245), ch. 258, p. 1360, § 4, effective May 23.

10-22-109. Funding for the operation of the exchange and reserves - special fees - rules. (1) On and after January 1, 2014, among other funding sources derived through the operation of the exchange, funding for the exchange may be from the following sources:

(a) Special fees assessed against insurers as provided in subsection (2) of this section; and

(b) Any moneys accepted through gifts, grants, or donations received by the board for operation, reserves, and sustainability of the exchange, including contributions received pursuant to the premium tax credit allocation in section 10-22-110.

(c) Repealed.

(2) (a) On and after January 1, 2014, through December 31, 2016, the board shall assess special fees against insurers in an amount necessary to provide funding for the exchange. The board shall determine the amount of the special fees based on the board-approved financial plan and anticipated budgetary needs for the upcoming year to comply with this article and associated federal requirements. The special fees must not exceed one dollar and eighty cents per number of lives insured per month; except that the special fees assessed for lives insured under dental plans must not exceed eighteen cents per number of lives insured per month. The board shall use special fees assessed pursuant to this section for the operating expenses of the exchange, the reserves of the exchange, and related agreements.

(b) The board shall use any money received pursuant to section 10-8-536 (2), as enacted in House Bill 13-1115, enacted in 2013, from the reserves of CoverColorado, as created by part 5 of article 8 of this title, and any moneys received from the unclaimed property trust fund to offset the amount of the fees assessed against insurers pursuant to this subsection (2); except that the money received must not be used to offset the special fees paid by dental plans.

(c) Amounts assessed against insurers to be paid to the exchange pursuant to this subsection (2) are not considered premiums for any purpose, including the computation of gross premium tax or agents' commission.

(d) If an insurer fails to pay the special assessment fee, the commissioner may, after proper notice and hearing, suspend or revoke the insurer's certificate of authority to transact insurance business in this state.

(3) The commissioner shall promulgate rules to implement this section that include:

(a) The reasonable time periods for the billing and collection of the special fees; and

(b) The process for determining the allocation of the assessment among insurers, including the process for obtaining accurate information about the number of policies issued and lives insured by an insurer within the six months prior to the assessment.

Source: L. 2013: Entire section added, (HB 13-1245), ch. 258, p. 1361, § 5, effective May 23. **L. 2017:** (1)(c) repealed, (SB 17-294), ch. 264, p. 1385, § 10, effective May 25.

10-22-110. Tax credit for contributions to the exchange - allocation notice - rules - repeal. (1) (a) For the tax year 2013 and each tax year thereafter, a credit against the tax imposed by sections 10-3-209 and 10-6-128 is allowed to any insurance company that becomes a qualified taxpayer by making a contribution to the exchange pursuant to this section.

(b) A qualified taxpayer claiming a credit against premium tax liability under this section is not required to pay any additional retaliatory tax as a result of claiming the credit.

(2) The commissioner may promulgate rules necessary for the administration of the tax credit allowed by subsection (1) of this section in accordance with article 4 of title 24, C.R.S.

(3) (a) Subject to subsection (4)(c) of this section, an insurance company shall become a qualified taxpayer if all of the following conditions are met:

(I) The insurance company declares with its quarterly tax payment due on or about July 31 in the manner prescribed by the commissioner its intent to contribute to the exchange on or before October 31 an amount of money equal to the premium taxes paid by the company pursuant to the July 31 tax payment or a lesser amount as specified by the commissioner if required pursuant to paragraph (b) of subsection (4) of this section;

(II) The total amount of the tax credits granted by the commissioner does not exceed five million dollars; except that, on and after September 1, 2022, through August 31, 2028, the total amount of the tax credits does not exceed nine million dollars; and

(III) The insurance company receives an allocation notice from the commissioner and the insurance company makes the contribution to the exchange as specified in the allocation notice on or before October 31.

(b) Subject to paragraph (c) of subsection (4) of this section, an insurance company that becomes a qualified taxpayer may claim the tax credit on one or more subsequent quarterly or annual tax payments beginning on or about October 31.

(c) The board shall promptly notify the commissioner when it receives a contribution pursuant to this section of the amount and date of the contribution and the name of the contributor.

(4) (a) Subject to paragraph (c) of this subsection (4), by September 30 of each year, the commissioner shall:

(I) Send an allocation notice to each insurance company whose declaration of intent to contribute to the exchange has been accepted pursuant to this subsection (4). The allocation notice shall specify the amount of tax credits allocated to the insurance company and the amount of cash the insurance company must contribute to the exchange by October 31, which amounts shall be identical and not exceed the amount of premium taxes paid by the insurance company in its quarterly tax payment due on or about July 31.

(II) Post on the division's website whether the full amount of tax credits authorized to be allocated each year has been allocated.

(b) (I) Subject to subsection (4)(c) of this section, the commissioner shall allocate no more than the following total amounts of premium tax credits per year:

(A) Before September 1, 2022, a total of five million dollars;

(B) On and after September 1, 2022, through August 31, 2028, a total of nine million dollars; and

(C) On and after September 1, 2028, a total of five million dollars.

(II) Except as provided in subsection (4)(b)(III) of this section, the commissioner shall allocate to an insurance company that has declared its intent to contribute to the exchange pursuant to this section tax credits in an amount equal to the amount of premium taxes paid by the insurance company in its quarterly tax payment due on or about July 31 in the order in which the division receives such quarterly tax payments until the full amount of credits available pursuant to this section has been allocated.

(III) If the amount of premium taxes or the sum of all the premium taxes filed by all the insurance companies on any one day would exceed, singly or in the aggregate, the annual maximum aggregate amount of tax credits available under this section, the commissioner shall reduce the allocation to the insurance company whose contribution first exceeds the annual maximum aggregate to the amount needed to satisfy the annual maximum aggregate. If the commissioner is unable to determine the order of receipt of tax payments on that day, the commissioner shall allocate the tax credits to the company or among the companies on a pro rata basis based on the ratio such company's quarterly tax payment bears to the total amount of all such companies' quarterly tax payments until the full amount of credits available pursuant to this section has been allocated.

(c) (I) The commissioner shall allow insurance companies to declare their intent to contribute to the exchange pursuant to this section on the insurance companies' quarterly tax payments due on or about October 31 and shall send such companies allocation notices by February 1 if:

(A) The full amount of tax credits available in any one year have not been fully allocated by the commissioner pursuant to statements of intent filed with insurance companies' quarterly tax payments due on or about July 31; or

(B) The total amount of tax credits has been claimed, but one or more insurance companies failed to timely make a contribution to the exchange.

(II) An insurance company that declares its intent to contribute to the exchange pursuant to this paragraph (c) shall make the contribution to the exchange as specified in the allocation notice on or before March 1 and may claim the tax credit on one or more subsequent quarterly or annual tax payments due on or about March 1.

(5) The board shall use money contributed to the exchange as follows:

(a) The amount of contributions from insurers to which the first five million dollars of tax credits is allocated pursuant to subsection (4)(b) of this section and the interest derived from the deposit and investment of the money, to operate and sustain the exchange and to build reserves; except that, on and after September 1, 2028, the total amount of contributions and interest derived from the deposit and investment of the money shall be used for the purposes specified in this subsection (5)(a).

(b) (I) Any amount of contributions from insurers to which any amount in excess of the first five million dollars of tax credits is allocated pursuant to subsection (4)(b) of this section and the interest derived from the deposit and investment of the money, for the public awareness and education campaign in section 10-22-115.

(II) This subsection (5)(b) is repealed, effective December 31, 2028.

Source: L. 2013: Entire section added, (HB 13-1245), ch. 258, p. 1362, § 5, effective May 23. **L. 2022:** IP(3)(a), (3)(a)(II), (4)(b), and (5) amended, (SB 22-081), ch. 448, p. 3160, § 2, effective August 10.

10-22-111. Tax exemption. The exchange is exempt from any tax levied by this state or any of its political subdivisions.

Source: L. 2013: Entire section added, (HB 13-1245), ch. 258, p. 1364, § 5, effective May 23.

10-22-112. Health benefit exchange - referral to private insurance brokers - fees - rules. (1) The exchange shall include the following in its protocol for interacting with consumers in order to assist consumers in enrolling in health benefit plans: Upon a consumer's contact with the exchange when seeking assistance in selecting a qualified health plan, whether online or by telephone, the exchange shall inform the consumer that he or she has the option of selecting coverage online, with the assistance of a navigator, or with the assistance of a qualified insurance broker. The exchange shall inform the consumer that a navigator may assist with a health benefit plan selection but may not offer advice on a health benefit plan based on the consumer's individual situation, whereas a qualified broker may offer advice based on the consumer's personal and family situation.

(2) The exchange shall maintain online tools that allow insurance brokers to develop and maintain client relationships for customers who are eligible to enroll in private health benefit plans, when appropriate, if the client requests this option.

(3) (a) An insurance broker may charge a client a fee for advising the client on the selection of an individual health benefit plan offered on the exchange only if the broker:

(I) Will not receive a commission from the insurer offering the individual health benefit plan selected by the client; and

(II) Provides a written disclosure to the client if the broker will charge a fee for the service.

(b) The commissioner may promulgate rules regarding the form and manner by which an insurance broker must provide the disclosure required by this subsection (3). The rules shall include a prohibition on a broker charging a fee to assist a client to enroll in medicaid or the children's basic health plan, as defined in section 25.5-8-103 (2).

Source: L. 2016: Entire section added, (SB 16-006), ch. 296, p. 1204, § 1, effective June 10. **L. 2018:** Entire section amended, (SB 18-136), ch. 118, p. 818, § 2, effective August 8.

10-22-113. Colorado affordable health care coverage easy enrollment program - advisory committee - creation - appointments - duties - definitions - repeal. (1) There is

hereby created the Colorado affordable health care coverage easy enrollment program for the purpose of leveraging the individual income tax filing process to maximize the enrollment of eligible uninsured individuals in a health-care coverage affordability program.

(2) (a) For the purpose of guiding the implementation and administration of the program, there is hereby created the affordable health care coverage easy enrollment advisory committee. The executive directors of the exchange and the department of revenue, or their designees, shall serve as co-chairs of the advisory committee. On or before September 1, 2020, the board shall appoint nine additional members, as specified in subsection (2)(b) of this section, to serve on the advisory committee. In making the appointments, the board shall consider the geographic, economic, ethnic, and other characteristics of the state.

(b) Members of the advisory committee must include:

(I) A representative of the department of health care policy and financing;

(II) A representative of the division;

(III) A representative of consumer advocacy groups;

(IV) A representative of small employers, as defined in section 10-16-102 (61);

(V) A representative of insurers;

(VI) A health-care consumer;

(VII) A health coverage guide or other person with expertise in the process of applying for federal insurance or assistance as provided by:

(A) Title XIX of the federal "Social Security Act", as amended, and the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5; or

(B) The children's basic health plan, as defined in article 8 of title 25.5;

(VIII) An insurance producer, as defined in section 10-2-103 (6); and

(IX) A provider of income tax preparation services.

(c) Of the members first appointed, in order to ensure staggered terms, the initial term of office of five of the members is two years and the initial term of office of four of the members is four years. Thereafter, the term of office of all members is four years.

(d) Members of the advisory committee may be removed for cause by the board or by a majority vote of the advisory committee members.

(e) The advisory committee shall meet as often as necessary to carry out its duties pursuant to this section.

(f) Members of the advisory committee are not entitled to receive per diem or other compensation for performance of services for the advisory committee but may be reimbursed for actual and necessary expenses, including any required dependent care and dependent or attendant travel, food, and lodging, while engaged in the performance of official duties of the advisory committee.

(g) This subsection (2) is repealed, effective September 1, 2030.

(3) (a) The advisory committee shall:

(I) Determine the minimum information necessary to collect through the state individual income tax forms to identify uninsured individuals and allow the exchange to assess whether they are potentially eligible for enrollment in a health-care coverage affordability program or other creditable coverage;

(II) Determine the procedures that will be used to transfer tax filer information from the department of revenue to the exchange in order to facilitate the program;

(III) Recommend revisions to the state individual income tax form, supplemental schedules, or both to be implemented by the department of revenue pursuant to section 39-22-5202 that are needed to implement the program. The recommendations must include:

(A) A question asking if the tax filer wants the exchange to assess whether the uninsured individuals in the tax household are potentially eligible for a health-care coverage affordability program or other creditable coverage using information from the tax filer's state individual income tax return and other sources available to the exchange;

(B) For tax filers that want the exchange to assess potential eligibility, a request for: The identity of the uninsured individuals and any additional information, including the household size of the tax filer, that is not otherwise available to the exchange and that is deemed essential by the advisory committee for making assessments of potential eligibility; except that the request for additional information shall not include requests for citizenship, immigration, or health status;

(IV) Draft recommended instructions for the individual tax form instruction booklet that explain how to answer the questions added to the tax return form or schedules pursuant to section 39-22-5202 (1)(b) and the effects of indicating that the tax filer would like the exchange to assess the eligibility of uninsured household members;

(V) Determine the process that the exchange will use under the program to assess potential eligibility for and assist with enrollment in a health-care coverage affordability program or other creditable coverage including:

(A) A timeline for assessing each individual's potential eligibility for a health-care coverage affordability program or other creditable coverage;

(B) A process to notify individuals regarding the outcomes of assessments of potential eligibility, which process is designed to maximize health-care coverage enrollment levels; and

(C) A process for handling uninsured individuals whose status as United States citizens cannot be verified through information available to the exchange; and

(VI) Determine the feasibility of and, if feasible, recommend a process for automatic enrollment, through the program, of eligible uninsured individuals in a medical assistance program under the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5, or other zero-net-premium creditable coverage.

(b) This subsection (3) is repealed, effective September 1, 2030.

(4) The exchange, through procedures determined by the advisory committee, shall:

(a) Assess whether uninsured individuals identified through the program are potentially eligible for a health-care coverage affordability program or other creditable coverage;

(b) Notify the uninsured individuals regarding their potential eligibility;

(c) Enroll or assist with enrolling the uninsured individuals in creditable coverage; and

(d) Not take additional steps to determine eligibility for or enroll an uninsured individual identified through the program if the exchange cannot verify that the uninsured individual is a United States citizen until the individual provides affirmative consent using procedures developed by the advisory committee pursuant to subsection (3)(a)(V)(C) of this section.

(5) As used in this section:

(a) (I) "Advisory committee" means the affordable health care coverage easy enrollment advisory committee.

(II) This subsection (5)(a) is repealed, effective September 1, 2030.

(b) "Creditable coverage" has the same meaning as set forth in section 10-16-102 (16).

(c) "Program" means the Colorado affordable health care coverage easy enrollment program.

(d) "Uninsured individual" means an individual who does not have creditable coverage.

Source: L. 2020: Entire section added, (HB 20-1236), ch. 236, p. 1144, § 3, effective September 14.

10-22-114. Standardized plan survey - repeal. (1) The exchange shall conduct a survey in collaboration with the division that addresses the experience of consumers who purchased the standardized health benefit plan established pursuant to section 10-16-1304. The survey must be completed on or before January 1, 2026.

(2) This section is repealed, effective July 1, 2026.

Source: L. 2021: Entire section added, (HB 21-1232), ch. 241, p. 1294, § 4, effective June 16.

10-22-115. Public awareness and education campaign - board - report - repeal. (1) (a) On or before July 1, 2023, the board shall create and implement a public awareness and education campaign in order to educate consumers in Colorado regarding the options for obtaining health-care coverage.

(b) (I) On or before September 1, 2023, the board shall use the public awareness and education campaign to educate consumers in Colorado on how to attain and retain health-care coverage based on their health-care needs and financial circumstances so they can access the health care they need. The campaign must include efforts to:

(A) Improve health literacy among consumers in Colorado;

(B) Assist consumers in Colorado who lose minimum essential coverage; and

(C) Reduce the number of individuals eligible for health-care coverage who remain uninsured or without health-care coverage.

(II) The campaign must include information about eligibility and costs where practicable.

(c) The public awareness and education campaign must include marketing and outreach to help consumers in this state who, at the end of the COVID-19 public health emergency as declared and extended by the United States secretary of health and human services, are no longer eligible for benefits under the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5, or the "Children's Basic Health Plan Act", article 8 of title 25.5, to understand coverage options and to transition to health-care coverage obtained through the exchange.

(d) The board may use print or electronic media, written material, social media, direct mail, or any effective means of outreach to create awareness and educate consumers throughout the campaign.

(2) The board shall annually report to the committee at the first scheduled meeting of the committee each calendar year starting in 2024. The board shall include in the report the following information:

(a) The public awareness and education campaign activities of the board in the prior calendar year;

(b) The amount of money spent on the campaign in the prior calendar year and a detailed accounting of how the money was spent; and

(c) Any recommendations of the board concerning changes to the public awareness and education campaign and the continuation or repeal of the duties of the board concerning the campaign.

(3) This section is repealed, effective December 31, 2028. The committee may report a bill to the legislative council of the general assembly pursuant to section 10-22-107 (5) to extend or eliminate the repeal date in this section.

Source: L. 2022: Entire section added, (SB 22-081), ch. 448, p. 3159, § 1, effective August 10.

ARTICLE 22.3

Opioid and Other Substance Use Disorders
Study Committee

10-22.3-101. Opioid and other substance use disorders study committee - creation - members - purposes. (1) (a) Notwithstanding section 2-3-303.3, there is hereby created the opioid and other substance use disorders study committee. The committee consists of ten members of the general assembly as follows:

(I) Five members of the senate, with three members appointed by the president of the senate and two members appointed by the minority leader of the senate; and

(II) Five members of the house of representatives, with three members appointed by the speaker of the house of representatives and two members appointed by the minority leader of the house of representatives.

(b) The speaker of the house of representatives shall appoint the chair of the committee in the 2023 interim and the vice-chair in the 2022 interim, and the president of the senate shall appoint the chair of the committee in the 2022 interim and the vice-chair in the 2023 interim.

(2) The committee shall:

(a) Study data, data analytics, and statistics on the scope of the substance use disorder problem in Colorado, including trends in rates of substance abuse, treatment admissions, and deaths from substance use;

(b) Study the current prevention, intervention, harm reduction, treatment, and recovery resources, including substance abuse prevention outreach and education, available to Coloradans, as well as public and private insurance coverage and other sources of support for treatment and recovery resources;

(c) Review the availability of medication-assisted treatment and whether pharmacists can prescribe those medications through the development of collaborative pharmacy practice agreements with physicians;

(d) Examine the measures that other states, the United States government, and other countries use to address substance use disorders, including evidence-based best practices and the use of evidence in determining strategies to treat substance use disorders, and best practices on the use of prescription drug monitoring programs;

(e) Identify the gaps in prevention, intervention, harm reduction, treatment, and recovery resources available to Coloradans and hurdles to accessing those resources;

(f) Identify possible legislative options to address gaps and hurdles to accessing prevention, intervention, harm reduction, treatment, and recovery resources;

(g) Examine law enforcement and criminal justice measures, including the prohibition of illegal drugs, penalties for trafficking illegal drugs, diversion, jail-based and prison-based treatment and reduction programs, and technologies and other requirements useful in enforcing laws removing opioid and other illegal substances;

(h) During the 2022 interim, study the relationship between mental health conditions and substance use disorders and examine treatment modalities that best serve individuals with co-occurring mental health conditions and substance use disorders, including the benefits of integrated services; and

(i) During the 2022 interim, study the impact of COVID-19, the coronavirus disease caused by the severe acute respiratory syndrome coronavirus 2, also known as SARS-CoV-2, on the provision of prevention, harm reduction, treatment and recovery support services, and related behavioral health services, including the impact related to the opioid crisis and drug overdoses, and prepare legislative recommendations for the general assembly for addressing the impacts.

(3) (a) The committee may meet up to six times per interim in the 2023 interim. The committee may recommend up to a total of five bills during each interim. Legislation recommended by the committee must be treated as legislation recommended by an interim committee for purposes of applicable deadlines, bill introduction limits, and any other requirements imposed by the joint rules of the general assembly.

(b) By December 1, 2023, the committee shall make a report and a final report, respectively, to the legislative council created in section 2-3-301 that may include recommendations for legislation.

(4) (a) Members of the committee are entitled to receive the usual per diem and necessary travel and subsistence expenses as provided pursuant to section 2-2-307 for members of the general assembly who attend interim committee meetings.

(b) The director of research of the legislative council and the director of the office of legislative legal services shall provide staff assistance to the committee.

Source: L. 2018: Entire article added, (HB 18-1003), ch. 224, p. 1425, § 1, effective May 21. **L. 2020:** IP(1)(a), (1)(b), (2)(f), and (3) amended and (2)(h) and (2)(i) added, (SB 20-028), ch. 186, p. 852, § 1, effective June 30. **L. 2021:** (1)(b), (2)(h), (2)(i), and (3) amended, (SB 21-137), ch. 362, p. 2382, § 30, effective June 28. **L. 2022:** (3)(a) and (3)(b) amended, (HB 22-1278), ch. 222, p. 1583, § 212, effective July 1, 2023. **L. 2025:** (3) amended, (SB 25-199), ch. 149, p. 567, § 7, effective April 30.

Cross references: For the short title "Behavioral Health Recovery Act of 2021" and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

10-22.3-102. Repeal of article. This article 22.3 is repealed, effective September 1, 2026.

Source: L. 2018: Entire article added, (HB 18-1003), ch. 224, p. 1427, § 1, effective May 21. **L. 2020:** Entire section amended, (SB 20-028), ch. 186, p. 853, § 2, effective June 30. **L. 2024:** Entire section amended, (HB 24-1045), ch. 470, p. 3292, § 30, effective August 7.

ARTICLE 22.5

Colorado High-risk Health Care Coverage Study

10-22.5-101 to 10-22.5-106. (Repealed)

Editor's note: (1) This article was added in 2017 and was not amended prior to its repeal in 2018. For the text of this article prior to 2018, consult the 2017 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

(2) Section 10-22.5-106 provided for the repeal of this article, effective June 30, 2018. (See L. 2017, p. 1692.)

CASH-BONDING AGENTS

ARTICLE 23

Cash-bonding Agents

10-23-101. Definitions. As used in this article, unless the context otherwise requires:

(1) "Cash-bonding agent" means a person who was licensed by the division as of January 1, 1992, to write bail bonds as a cash-bonding agent.

(2) "On the board" means that the name of the person has been publicly posted or disseminated by a court as being ineligible to write bail bonds under section 16-4-114 (5)(e) or (5)(f), C.R.S.

(3) "Professional cash-bail agent" means a person who furnishes bail for compensation in any court or courts in this state in connection with judicial proceedings by posting a bond with the division. "Professional cash-bail agent" does not mean a full-time salaried officer or employee of an insurer nor a person who pledges United States currency, a United States postal money order, a cashier's check, or other property in connection with a judicial proceeding, whether for compensation or otherwise.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1509, § 41, effective July 1. **L. 2013:** (2) amended, (HB 13-1236), ch. 202, p. 841, § 7, effective May 11.

Editor's note: This section is similar to former § 12-7-101 as it existed prior to 2012.

10-23-102. Registration required - qualifications - enforcement. (1) No person qualifies to be a professional cash-bail agent unless the person registers with the division. However, any bail bonding agent who was licensed by the division as of January 1, 1992, to

write bail bonds as a cash-bonding agent may continue to be registered upon compliance with the other requirements of this article.

(2) No firm, partnership, association, or corporation, as such, shall be registered. No person engaged as a law enforcement or judicial officer shall be registered as a cash-bonding agent or professional cash-bail agent.

(3) (a) All registrations expire in accordance with a schedule established by the commissioner, and the registrant shall renew or reinstate the registration in accordance with the rules of the commissioner. If the commissioner schedules a registration to expire for longer or shorter than a year, the commissioner shall proportionally adjust the renewal fee for the registration. The registrant must satisfy all registration and renewal requirements to qualify to register.

(b) The commissioner shall give a registrant a sixty-day grace period to renew the registration without discipline or sanctions. The commissioner may establish renewal fees and delinquency fees for reinstatement by rule. If a person fails to renew a registration when required by the schedule established by the commissioner, the registration expires.

(4) The division shall transmit all fees collected under this article to the state treasurer, who shall credit the fees to the division of insurance cash fund created in section 10-1-103.

(5) The division shall prepare and deliver to each registrant a pocket card showing the name, address, and classification of the registrant. The pocket card must clearly state that the person is authorized to practice as a cash-bonding agent or professional cash-bail agent.

(6) Repealed.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1510, § 41, effective July 1.

Editor's note: (1) This section is similar to former § 12-7-102 as it existed prior to 2012.

(2) Subsection (6)(d) provided for the repeal of subsection (6), effective July 1, 2015. (See L. 2012, p. 1510.)

10-23-103. Registration requirements - application. (1) An applicant for registration as a professional cash-bail agent shall supply the following information to the division:

(a) Whether the applicant during the last ten years has been convicted of a felony, entered a guilty plea to a felony, accepted a plea of nolo contendere to a felony, or engaged in or committed an act that violates this article, a rule promulgated under this article, or any act that would violate this article or a rule promulgated under this article if it had been committed in Colorado; and

(b) Any other information required by this article or by the division, including a full-face photograph, for which the applicant shall pay the actual costs if a photograph is required.

(2) (a) Prior to submission of an application pursuant to this article 23, each applicant shall have his or her fingerprints taken by a local law enforcement agency or any third party approved by the Colorado bureau of investigation to obtain a fingerprint-based criminal history record check. If a third party takes the person's fingerprints, the fingerprints may be electronically captured using Colorado bureau of investigation-approved livescan equipment. Third-party vendors shall not keep the applicant information for more than thirty days unless

requested to do so by the applicant. The applicant is required to submit payment by certified check or money order for the fingerprints and for the actual costs of the record check when the fingerprints are submitted to the Colorado bureau of investigation. Upon receipt of fingerprints and receipt of the payment for costs, the Colorado bureau of investigation shall conduct a state and national fingerprint-based criminal history record check utilizing records of the Colorado bureau of investigation and the federal bureau of investigation.

(b) When the results of a fingerprint-based criminal history record check of an applicant performed pursuant to this subsection (2) reveal a record of arrest without a disposition, the division shall require that applicant to submit to a name-based judicial record check, as defined in section 22-2-119.3 (6)(d).

(3) To qualify as a professional agent, the applicant must have been licensed as an insurance producer who furnishes bail in Colorado for four years before applying for registration as a professional cash-bail agent.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1512, § 41, effective July 1. **L. 2017:** (2) amended, (SB 17-189), ch. 149, p. 497, § 1, effective August 9. **L. 2019:** (2) amended, (HB 19-1166), ch. 125, p. 538, § 5, effective April 18. **L. 2022:** (2)(b) amended, (HB 22-1270), ch. 114, p. 514, § 7, effective April 21.

Editor's note: Subsections (1) and (2) are similar to former § 12-7-103, and subsection (3) is similar to former § 12-7-102.5 (7), as they existed prior to 2012.

10-23-104. Fees. (1) (a) Each professional cash-bail agent and cash-bonding agent shall pay an application fee set by the division in an amount to offset the direct and indirect cost of processing registration applications and issuing a registration.

(b) Each professional cash-bail agent and cash-bonding agent shall pay a registration renewal fee set by the division in an amount that offsets the direct and indirect cost of implementing this article, net of the total amount of the fees paid by that agent under paragraph (c) of this subsection (1).

(c) Each professional cash-bail agent and cash-bonding agent shall pay to the division a fee of one percent on the gross amount of all premiums and fees collected or contracted for the furnishing of bail, less any premium or fee refunded after being collected. The division may lower the fee if the amount collected would exceed the amount needed to implement this article plus a reserve of sixteen and one-half percent.

(d) The premium fee is due and payable on the fifteenth day of January in each year. Any professional cash-bail agent or cash-bonding agent failing or refusing to render a statement and information, or to pay the fee under this section, for more than thirty days after the time specified, is liable for a penalty of up to one hundred dollars for each additional day of delinquency. The division may assess the penalty and interest at a rate of one percent per month or fraction thereof on the unpaid amount from the date when payment was due to the date when full payment is made. The division may suspend the registration of a delinquent agent until any fees, penalties, and interest are fully paid.

(2) The division shall transfer the fees imposed by this section to the treasurer, who shall credit the fee to the division of insurance cash fund created in section 10-1-103.

(3) For the purpose of auditing a professional cash-bail agent's or cash-bonding agent's premium fee statement, the division may examine any books, papers, records, agreements, or memoranda bearing upon the matters required to be included in the premium fee statement. The agent shall make the books, papers, records, agreements, or memoranda available upon request to the division.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1514, § 41, effective July 1.

10-23-105. Qualification bond - forfeiture. (1) Each cash-bonding agent shall post a cash qualification bond of fifty thousand dollars with the division. The bond must be to the people of the state of Colorado in favor of any court in this state, whether municipal, county, district, or other court, and to the division for the purposes of this section. In the event of a forfeiture of a cash-bonding agent's qualification bond, the division has priority over all other claimants. To comply with this subsection (1), the bond must be conditioned upon full and prompt payment into the court ordering the bond forfeited. Cash-bonding agents shall not issue bonds except in accordance with section 16-4-104 (1)(c)(III), C.R.S. In the event of a qualification bond forfeiture, a cash-bonding agent shall not write new bail bonds until the qualification bond is restored to fifty thousand dollars.

(2) Each professional cash-bail agent shall post a cash qualification bond of no less than fifty thousand dollars with the division. The bond shall be to the people of the state of Colorado in favor of any court in this state, whether municipal, county, district, or other court, and to the division for the purposes of this section. A professional cash-bail agent shall not furnish a single bail greater than twice the amount of the bond posted with the division. In the event of a forfeiture of a professional cash-bail agent's qualification bond, the division has priority over all other claimants to the bond. To comply with this subsection (2), the bond must be conditioned upon full and prompt payment into the court ordering the bond forfeited. Professional cash-bail agents shall not issue bonds except in accordance with section 16-4-104 (1)(c)(III), C.R.S. In the event of a qualification bond forfeiture, a professional cash-bail agent shall not write new bail bonds until the qualification bond is restored to at least fifty thousand dollars.

(3) To comply with this section, the division must be designated as an authorized signatory with right of survivorship on any bank account, certificate of deposit, commercial instrument, or security that funds the bond required by this section. The right of survivorship terminates on the later of the date on which any liability covered by the bond is satisfied or released or the third anniversary of the death of the professional cash-bail agent or cash-bonding agent. When the right of survivorship terminates, the division shall release the bond to the agent's estate or, if the estate has been settled, to the heirs of the agent.

(4) To qualify under this section:

(a) A bank account, certificate of deposit, commercial instrument, or security must be in the legal name of the professional cash-bail or cash-bonding agent and not a trade name or other business name;

(b) The qualification bond must consist of assets that are solely owned and in the name of the professional cash-bail or cash-bonding agent and be immediately available for liquidation by the commissioner or the division;

(c) The qualification bond must be worth fifty thousand dollars net of any penalty for withdrawal or liquidation;

(d) The professional cash-bail or cash-bonding agent may receive interest thereon, unless the principal amount of the qualification bond falls below the required fifty thousand dollars, if the qualification bond is an interest-bearing instrument;

(e) The terms of the loan, promissory note, and financial arrangement must be submitted to the division if the qualification bond is funded by the proceeds from a loan, promissory note, or other financial arrangement; and

(f) The agreement must terminate at a fixed time and any rate of return is an annual percentage rate and not tied to any premium or collateral or any other direct function from which an agent makes a profit if the qualification bond consists of moneys from a loan, promissory note, or other financial arrangement.

(5) Upon request by the person who posted the qualification bond to be registered under this article, the commissioner shall release the bond if the person has not been registered or licensed to write a bond as a professional cash-bail agent or cash-bonding agent within the last seven years. Neither the commissioner nor the division are liable to any other party for releasing the qualification bond in accordance with this section.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1515, § 41, effective July 1. **L. 2013:** (1) and (2) amended, (HB 13-1236), ch. 202, p. 841, § 8, effective May 11.

Editor's note: Subsection (1) is similar to former § 12-7-103 (3)(a), and subsection (2) is similar to former § 12-7-103 (8)(a), as they existed prior to 2012.

10-23-106. Discipline - hearing - civil penalty. (1) The division may deny, suspend, revoke, or refuse to renew a registration, or issue a cease-and-desist order in accordance with this section, upon reasonable grounds that the registrant:

(a) Failed to post a qualified bond in the required amount with the division while engaged in business or, if the bond was posted, it was forfeited or canceled;

(b) Knowingly failed to comply with or knowingly violated this article or any proper order or rule of the division or any court of this state where the registrant knew or reasonably should have known of the order or rule;

(c) Violated section 18-13-130, C.R.S.;

(d) Was convicted of a felony or pled guilty or nolo contendere to a felony within the last ten years, regardless of whether the conviction or plea resulted from conduct in or conduct related to the bail bond business;

(e) Served a sentence upon a conviction of a felony in a state correctional facility, city or county jail, or community correctional facility or under the supervision of the state board of parole or any probation department within the last ten years;

(f) Continued to execute bail bonds in any court in this state while on the board if the bail forfeiture judgment that resulted in the registrant's being placed on the board has not been paid, stayed, vacated, exonerated, or otherwise discharged;

(g) Furnished bail in any court in this state in an amount greater than twice the amount of the professional cash-bail agent's bond posted with the division;

(h) Failure to report, preserve without use, retain separately, or return after payment in full, collateral taken as security on any bail bond to the principal, indemnitor, or depositor of the collateral;

(i) Soliciting bail bond business in or about any place where prisoners are confined, arraigned, or in custody;

(j) Failure to pay a final, nonappealable judgment award for failure to return or repay collateral received to secure a bond; or

(k) Any act prohibited by section 18-13-130, C.R.S.

(2) Except for the reasons listed in paragraphs (d) and (e) of subsection (1) of this section, the division, in lieu of revoking or suspending a registration, may in any one proceeding, by order, require the registrant to pay a civil penalty in the sum of no less than three hundred dollars and no more than one thousand dollars for each offense. If the registrant fails to pay the penalty within twenty days after the mailing of the order, postage prepaid, registered and addressed to the last-known place of business of the registrant, the division may revoke the registration or may suspend the registration for such a period as the commissioner may determine, unless the order is stayed by a court of competent jurisdiction. The division shall transmit the civil penalty to the state treasurer, who shall deposit it in the general fund.

(3) Except as otherwise provided in this section, the commissioner need not find that the actions that are grounds for discipline were willful but may consider whether the actions were willful when determining the nature of disciplinary sanctions to be imposed.

(4) (a) The commissioner may commence a proceeding to discipline a registrant when the commissioner has reasonable grounds to believe that the registrant has committed an act enumerated in this section.

(b) In any proceeding held under this section, the commissioner may accept as evidence of grounds for disciplinary action any disciplinary action taken against a registrant in another jurisdiction if the violation that prompted the disciplinary action in the other jurisdiction would be grounds for disciplinary action under this article.

(5) Disciplinary proceedings, hearings, and opportunity for review must be conducted in accordance with article 4 of title 24, C.R.S., by the commissioner or by an administrative law judge, at the commissioner's discretion. The commissioner may exercise all powers and duties conferred by this article during the disciplinary proceedings.

(6) (a) The commissioner may request the attorney general to seek an injunction, in any court of competent jurisdiction, to enjoin a person from committing an act prohibited by this article. When seeking an injunction under this paragraph (a), the attorney general shall not be required to allege or prove the inadequacy of any remedy at law or that substantial or irreparable damage is likely to result from a continued violation of this article.

(b) (I) The commissioner may investigate, hold hearings, and gather evidence in all matters related to the exercise and performance of the powers and duties of the commissioner.

(II) In order to aid the commissioner in any hearing or investigation instituted under this section, the commissioner or an administrative law judge appointed by the commissioner may administer oaths, take affirmations of witnesses, and issue subpoenas compelling the attendance of witnesses and the production of all relevant records, papers, books, documentary evidence, and materials in any hearing, investigation, accusation, or other matter before the commissioner or an administrative law judge.

(III) Upon failure of any witness or registrant to comply with a subpoena or process, the district court of the county where the subpoenaed person or registrant resides or conducts business, upon application by the commissioner with notice to the subpoenaed person or registrant, may issue to the person or registrant an order requiring the person or registrant to appear before the commissioner; to produce the relevant papers, books, records, documentary evidence, or materials if so ordered; or to give evidence touching the matter under investigation or in question. If the person or registrant fails to obey the order of the court, the person or registrant may be held in contempt of court.

(c) The commissioner may appoint an administrative law judge under part 10 of article 30 of title 24, C.R.S., to conduct hearings, take evidence, make findings, and report the findings to the commissioner.

(7) (a) The commissioner, the commissioner's staff, any person acting as a witness or consultant to the commissioner, any witness testifying in a proceeding authorized under this article, and any person who lodges a complaint pursuant to this article is immune from liability in any civil action brought against him or her for acts occurring while acting in his or her capacity as commissioner, staff, consultant, or witness, respectively, if such individual was acting in good faith within the scope of his or her respective capacity, made a reasonable effort to obtain the facts of the matter as to which he or she acted, and acted in the reasonable belief that the action taken by him or her was warranted by the facts.

(b) A person participating in good faith in making a complaint or report or in an investigative or administrative proceeding under this section is immune from any civil or criminal liability that otherwise might result by reason of the participation.

(8) A final action of the commissioner is subject to judicial review by the court of appeals pursuant to section 24-4-106 (11), C.R.S. A judicial proceeding to enforce an order of the commissioner may be instituted in accordance with section 24-4-106 (3), C.R.S.

(9) When a complaint or an investigation discloses an instance of misconduct that, in the opinion of the commissioner, warrants formal action, no person shall resolve the complaint by a deferred settlement, action, judgment, or prosecution.

(10) (a) If it appears to the commissioner, based upon credible evidence as presented in a written complaint by any person, that a registrant is acting in a manner that is an imminent threat to the health and safety of the public, or that a person is acting or has acted without the required registration, the commissioner may issue an order to cease and desist such activity. The order must set forth the statutes and rules alleged to have been violated, the facts alleged to have constituted the violation, and the requirement that all unlawful acts or unregistered practices immediately cease.

(b) Within ten days after service of the order to cease and desist under paragraph (a) of this subsection (10), the registrant may request a hearing on the question of whether acts or practices in violation of this article have occurred. The hearing must be conducted pursuant to sections 24-4-104 and 24-4-105, C.R.S.

(11) (a) If it appears to the commissioner, based upon credible evidence as presented in a written complaint by any person, that a person has violated any other portion of this article, then, in addition to any specific powers granted pursuant to this article, the commissioner may issue to the person an order to show cause as to why the commissioner should not issue a final order directing the person to cease and desist from the unlawful act or unregistered practice.

(b) The commissioner shall notify a person against whom an order to show cause has been issued of the issuance of the order, along with a copy of the order, the factual and legal basis for the order, and the date set by the commissioner for a hearing on the order. The notice may be served on the person against whom the order has been issued by personal service or by certified, postage-prepaid, United States mail. Personal service or mailing of an order or document constitutes notice of the order to the person.

(c) (I) The commissioner shall hold the hearing on an order to show cause no sooner than ten and no later than forty-five calendar days after the date of transmission or service of the notification by the commissioner as provided in this subsection (11). The hearing may be continued by agreement of all parties based upon the complexity of the matter, number of parties to the matter, and legal issues presented in the matter.

(II) If a person against whom an order to show cause has been issued does not appear at the hearing, the commissioner may present evidence that notification was properly sent or served on the person under this subsection (11) and such other evidence related to the matter as the commissioner deems appropriate. The commissioner shall issue the order within ten days after the commissioner's determination related to reasonable attempts to notify the respondent, and the order shall become final as to that person by operation of law. The commissioner shall conduct the hearing in accordance with sections 24-4-104 and 24-4-105, C.R.S.

(III) If the commissioner reasonably finds that the person against whom the order to show cause was issued is acting or has acted without the required licensure, or has or is about to engage in acts or practices constituting violations of this article, a final cease-and-desist order may be issued, directing the person to cease and desist from further unlawful acts or unregistered practices.

(IV) The commissioner shall provide notice, in the manner set forth in this subsection (11), of the final cease-and-desist order within ten calendar days after the hearing is conducted to each person against whom the final order has been issued. The final order issued is effective when issued and is a final order for purposes of judicial review.

(12) If it appears to the commissioner, based upon credible evidence presented to the commissioner, that a person has engaged or is about to engage in an unregistered act or practice; an act or practice constituting a violation of this article, a rule promulgated under this article, or an order issued under this article; or an act or practice constituting grounds for administrative sanction under this article, the commissioner may enter into a stipulation with the person.

(13) If any person fails to comply with a final cease-and-desist order or a stipulation, the commissioner may request the attorney general or the district attorney for the judicial district in which the alleged violation exists to bring, and if so requested, the attorney general shall bring suit for a temporary restraining order and for injunctive relief to prevent any further or continued violation of the final order.

(14) A person aggrieved by the final cease-and-desist order may seek judicial review of the commissioner's determination or of the commissioner's final order as provided in subsection (8) of this section.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1517, § 41, effective July 1.

Editor's note: This section is similar to former § 12-7-106 as it existed prior to 2012.

10-23-107. Unlicensed practice - penalties. A person who acts or attempts to act as a professional cash-bail agent or cash-bonding agent and who is not registered as such under this article 23 commits a class 2 misdemeanor. Upon conviction, the court shall require the person to disgorge any profits from acting as a professional cash-bail agent or cash-bonding agent and forward the profits to the state treasurer, who shall deposit the moneys in the general fund.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1522, § 41, effective July 1. **L. 2021:** Entire section amended, (SB 21-271), ch. 462, p. 3149, § 118, effective March 1, 2022.

Editor's note: This section is similar to former § 12-7-109 (3) as it existed prior to 2012.

Cross references: For the penalty for a class 2 misdemeanor, see § 18-1.3-501.

10-23-108. Bail bond documents - requirements - rules. (1) The professional cash-bail agent or cash-bonding agent who posts a bail bond with the court on behalf of a defendant shall ensure that the following documents comply with the following provisions:

(a) An indemnity agreement must:

(I) Be in writing;

(II) Be signed by the professional cash-bail agent or cash-bonding agent;

(III) Be signed by the defendant or indemnitor;

(IV) Set forth the amount of bail set in the case, the name of the defendant released on the bail bond, the court case number if available, the court where the bond is executed, the premium charged, the amount and type of collateral held by the professional cash-bail agent or cash-bonding agent, and the conditions under which the collateral is returned;

(V) Contain documentation that the indemnitor has received copies of signed and dated disclosure forms; and

(VI) If the defendant or indemnitor is illiterate or does not read English, contain a note on the indemnity agreement that the agent or a third party has read or translated the agreement to the defendant or indemnitor and be affixed with an affidavit to the indemnity agreement attesting that the document was translated;

(b) A promissory note must be:

(I) In writing;

(II) Signed by the professional cash-bail agent or cash-bonding agent; and

(III) Signed by the defendant or indemnitor;

(c) A collateral receipt must:

(I) Be dated;

(II) Be in writing;

(III) Be signed by the professional cash-bail agent or cash-bonding agent;

(IV) Be signed by the defendant or indemnitor;

(V) Be prenumbered;

(VI) Contain a full description of the collateral, including the condition of the collateral at the time it is taken into custody; and

(VII) Set forth the amount of bail set in the case, the name of the defendant released on the bail bond, the court case number, the court where the bond is executed, the premium charged,

the amount and type of collateral held by the agent, and the conditions under which the collateral is returned;

(d) A bail bond revocation request must be:

(I) Dated;

(II) In writing;

(III) Signed by the professional cash-bail agent or cash-bonding agent; and

(IV) Signed by the defendant or indemnitor.

(2) (a) Before accepting consideration, the professional cash-bail agent or cash-bonding agent shall commit to writing, sign, date, and obtain the defendant's or indemnitor's signature on an arrangement for the payment of all or part of the premium, commission, or fee, including the payment schedule. The signature of the professional cash-bail agent or cash-bonding agent is not an obligation to pay any debt owed to a lender. To be enforceable, interest and financial charges on any unpaid premium must comply with the "Uniform Consumer Credit Code", articles 1 to 9 of title 5, C.R.S.

(b) Before accepting consideration or taking collateral, the professional cash-bail agent or cash-bonding agent shall provide, in a form prescribed by the commissioner, a disclosure statement to each defendant and indemnitor detailing the terms of the bail bond.

(3) (a) A professional cash-bail agent or cash-bonding agent who accepts consideration for a bail bond or undertaking shall, for each payment received, provide to the person tendering payment a prenumbered, signed receipt containing the following:

(I) The date;

(II) The defendant's name;

(III) A description of the consideration and amount of money received;

(IV) The purpose for which it was received;

(V) The penal sum of the bail bond;

(VI) The name of the person tendering payment; and

(VII) The terms under which the money or other consideration is released.

(b) The professional cash-bail agent or cash-bonding agent shall provide the person tendering payment a signed and dated receipt for each premium payment listing the amount paid.

(3.5) (a) If the bond is to be secured by real estate, the bail bonding agent shall provide the property owner with a written disclosure statement in the following form at the time an initial application is filed:

Disclosure of lien against real property

Do not sign this document until you read and understand it! This bail bond will be secured by real property you own or in which you have an interest. Failure to pay the bail bond premiums when due or the defendant's failure to comply with the conditions of bail could result in the loss of your property!

(b) The disclosure required in paragraph (a) of this subsection (3.5) shall be printed in fourteen-point, bold-faced type either:

(I) On a separate and specific document attached to or accompanying the application; or

(II) In a clear and conspicuous statement on the face of the application.

(c) Before a property owner executes any instrument creating a lien against real property, the bail bonding agent shall provide the property owner with a completed copy of the

instrument creating the lien against real property and the disclosure statement described in paragraph (a) of this subsection (3.5). If a bail bonding agent fails to comply fully with the requirements of paragraphs (a) and (b) of this subsection (3.5) and this paragraph (c), any instrument creating a lien against real property shall be voidable.

(d) (I) The bonding agent shall deliver to the property owner a fully executed and notarized reconveyance of title, a certificate of discharge, or a full release of any lien against real property that secures performance of the conditions of a bail bond within thirty-five days after receiving notice that the time for appealing an order that exonerated the bail bond has expired. The bonding agent shall also deliver to the property owner the original canceled note, as evidence that the indebtedness secured by any lien instrument has been paid or that the purposes of the instrument have been fully satisfied, and the original deed of trust, security agreement, or other instrument that secured the bail bond obligation. If a timely notice of appeal is filed, the thirty-five-day period begins on the day the appellate court's affirmation of the order becomes final.

(II) If the bonding agent fails to comply with the requirements of this subsection (3.5)(d), the property owner may petition the district court to issue an order directing the clerk of the court to execute a full reconveyance of title, a certificate of discharge, or a full release of any lien against real property created to secure performance of the conditions of the bail bond. To be accepted by the court, the petition must be verified and allege facts showing that the bonding agent has failed to comply with the provisions of this subsection (3.5)(d).

(III) (A) If a bonding agent fails to comply with this subsection (3.5)(d), the property owner may file a complaint with the commissioner requesting that the commissioner petition a district court to file for record a full release of any lien against real property securing performance of the conditions of the bail bond.

(B) To be accepted by the commissioner, the complaint must be verified and allege facts showing that the bonding agent has failed to comply with this subsection (3.5)(d). The complaint must include a copy of the lien the property owner is requesting be released.

(C) Upon receipt of a verified complaint meeting the requirements of subsection (3.5)(d)(III)(B) of this section, the commissioner shall mail a copy of the complaint to the bonding agent at the bonding agent's last-known address.

(D) If the time for appealing an order that exonerated the bail bond has expired at least three years before the complaint is filed, and if the commissioner does not receive a reply from the bonding agent contesting the release of the lien within thirty-five days after mailing the complaint required in subsection (3.5)(d)(III)(C) of this section, the commissioner may petition the district court to issue an order directing the clerk of the court to execute a full reconveyance of title, a certificate of discharge, or a full release of any lien against real property created to secure performance of the conditions of the bail bond. Upon the court issuing an order executing a full reconveyance of title, issuing a certificate of discharge, or releasing the lien, the commissioner shall send a copy of the lien release documents to the bonding agent.

(E) If the commissioner receives, within thirty-five days after mailing the complaint to the bonding agent, a reply from the bonding agent contesting the factual basis of the property owner's complaint, the commissioner shall inform the property owner that the property owner must petition the district court to release the lien.

(e) Any bail bonding agent who violates this subsection (3.5) shall be liable to the property owner for all damages that may be sustained by reason of the violation, plus statutory

damages in the sum of three hundred dollars. The property owner shall be entitled to recover court costs and reasonable attorney fees, as determined by the court, upon prevailing in any action brought to enforce the provisions of this subsection (3.5).

(4) The professional cash-bail agent or cash-bonding agent shall prepare or execute separate agreements and documents for each time the agent posts a bail bond with the court. The agent shall give the indemnitor a copy of each document executed in the course of the bail bond transaction.

(5) For three years after the date of discharge of a bail bond and return of any collateral or proof of notice to the defendant or indemnitor that any promissory note has been satisfied, the professional cash-bail agent or cash-bonding agent shall keep at the agent's business, copies of each receipt, indemnity agreement, bond, disclosure statement, payment plan, bond revocation request, or other document or information related to the bond transaction and shall make these documents available for inspection by the commissioner or the commissioner's authorized representative during normal business hours.

(6) The indemnitor may be the defendant.

(7) The commissioner may examine the business practices, books, and records of any professional cash-bail agent or cash-bonding agent as often as the commissioner deems appropriate.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1522, § 41, effective July 1. **L. 2013:** (3.5) added, (HB 13-1236), ch. 202, p. 842, § 9, effective May 11. **L. 2017:** (3.5)(d) amended, (SB 17-236), ch. 312, p. 1678, § 3, effective August 9.

10-23-109. Business practices - price limits - collateral. (1) A professional cash-bail agent or cash-bonding agent shall not charge a premium or commission of more than the greater of fifty dollars or fifteen percent of the amount of bail furnished. A professional cash-bail agent or cash-bonding agent shall not assess fees for any bail bond posted by the agent with the court unless the fee is for payment of a bail bond filing charged by a court or law enforcement agency, the fee is for the actual cost of storing collateral in a secure, self-service public storage facility, or the fee is for premium financing.

(2) If a professional cash-bail agent or cash-bonding agent has issued a disclosure statement in accordance with section 10-23-108 (2)(b), the agent may use collateral received from the defendant or indemnitor to secure the following obligations:

(a) Compliance with the bond issued on behalf of the principal;

(b) Any balance due on the premium, commission, or fee for the bail bond; and

(c) Any actual costs incurred by the professional cash-bail agent or cash-bonding agent as a result of issuing the bail bond.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1525, § 41, effective July 1.

10-23-110. Repeal of article - review of functions. This article 23 is repealed, effective September 1, 2026. Before its repeal, the functions of the commissioner and the division shall be reviewed in accordance with section 24-34-104.

Source: L. 2012: Entire article added with relocations, (HB 12-1266), ch. 280, p. 1525, § 41, effective July 1. **L. 2017:** Entire section amended, (SB 17-236), ch. 312, p. 1677, § 1, effective August 9.

Editor's note: This section is similar to former § 12-7-112 as it existed prior to 2012.