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Life and Health Insurance

COLORADO | Law Supplement



LIFE AND HEALTH INSURANCE COLORADO LAW SUPPLEMENT,
EFFECTIVE JANUARY 16, 2009
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INTRODUCTION

This supplement focuses on statutes regarding Colorado insurance law. Key aspects of each statute are discussed to help the student pass the state law portion of the licensing examination. In order to understand the content of this supplement, the student should first study the national insurance License Exam Manual. Thorough preparation for the exam requires the complete study of both the national License Exam Manual and the supplement.

I. COLORADO STATUTES, RULES, AND REGULATIONS COMMON TO LIFE, SICKNESS, AND ACCIDENT INSURANCE

A. INSURANCE COMMISSIONER The Commissioner of Insurance is appointed by and at the will of the Governor. The Commissioner must be well versed in insurance and have no financial interest in any insurer or agency.

1. Power and duties [Secs. 10-1-104; 10-1-105; 10-1-108; 10-1-109; 10-1-201 through 204; 10-3-105; 10-3-202 through 208; 10-3-1106]

a. The Commissioner's duties include the following.

- 1.)** The Commissioner must maintain records that insurers are required by law to file in the Commissioner's office, including a statement of the condition of each insurer examined by the Commissioner.
- 2.)** The Commissioner must require domestic insurers to keep adequate records so that the Commissioner can verify annual statements and confirm that a company is solvent and complies with the law.
- 3.)** The Commissioner must examine applications for licenses or certificates of authority and issuing or refusing to issue licenses or certificates of authority.
 - a.)** A certificate of authority is an insurer's license to transact insurance business in Colorado.
 - An insurer may not conduct insurance business in Colorado without first receiving a certificate of authority from the Commissioner.
 - b.)** A company that has a certificate of authority is referred to as an **authorized insurer**.
 - A company that has not been issued a certificate of authority is referred to as a **nonadmitted insurer**.
- 4.)** The Commissioner must investigate violations of insurance laws and, when appropriate, present the findings to the district attorney.

- 5.) The Commissioner must prepare an annual report for the Governor and the general assembly that describes the performance of the Commissioner's duties.
 - 6.) The Commissioner must oversee the insurance business in Colorado to ensure that it is conducted according to state law and in the best interests of the public.
 - 7.) The Commissioner must transmit funds collected by the division of insurance to the state Department of the Treasury.
 - 8.) The Commissioner must evaluate long-term care insurance policies to determine their compliance with insurance law and providing insurers with a written statement of the results.
 - 9.) The Commissioner must adopt rules and regulations to carry out his duties.
- b. The Commissioner cannot perform all these duties alone, so he must hire employees to help carry them out. For example, the Deputy Commissioner performs the Commissioner's duties in the Commissioner's absence.
- 1.) The Commissioner may hire an experienced actuary to perform the actuarial duties of the insurance division.
- c. The Commissioner or a qualified examiner working on the Commissioner's behalf shall conduct a formal financial examination of every insurer licensed in this state at least every five years.
- 1.) In determining their nature, scope, and frequency, the Commissioner will consider standard financial criteria including, but not limited to, those set forward in the most recent examiner's handbook adopted by the NAIC.
 - 2.) If a company or any of its officers, directors, employees, or agents refuses to comply with examiners' written requests, the company could have its license suspended, revoked, denied, or nonrenewed.
 - 3.) The costs of examinations that must be conducted out of state will be paid by the insurance company.
- d. **Investigating possible violations** The Commissioner has the power to examine the affairs of any person doing insurance business in Colorado to determine whether that person has engaged in any unfair method of competition or any unfair or deceptive act.
- e. The Commissioner may also examine the affairs of any insurer doing business in Colorado. The Commissioner, or the assigned examiner, is allowed

free access to books and documents relating to the insurer's business and may subpoena witnesses and administer oaths during an investigation.

- f.** Anyone who intentionally testifies falsely during an examination is guilty of a misdemeanor and may be fined up to \$5,000, imprisoned for up to three months, or both. Anyone who falsifies an insurer's books or documents with the intent to deceive the Commissioner is guilty of a misdemeanor and faces a fine of up to \$5,000, imprisonment for between two and 12 months, or both.
 - g.** The Commissioner may also examine companies upon the request of five or more policyholders who have at least \$100,000 worth of insurance in force. The policyholders must specify in writing their reasons for believing the company is unsound or insolvent.
 - h.** The Commissioner may examine and investigate any person applying for or holding an insurance producer license to determine whether such person has violated the insurance laws or rules of the state or any other state.
 - 1.)** If the Commissioner receives information regarding a possible violation, such a person may be required to appear at a hearing to explain why the Commissioner should not revoke, suspend, or refuse to issue or renew that person's license.
 - 2.)** If an individual's conduct merits such punishment, the Commissioner may suspend or revoke the license of that individual's insurance agency if one of the partners, officers, or managers knew or should have known about the individual's violation.
 - 3.)** A civil fine of not more than \$1,000 is also a possible punishment for each violation.
 - 4.)** The Commissioner must promptly notify the insurance producer licensee as well as the central office of the NAIC and all state boards.
 - 5.)** Typically, the Commissioner or one of the Commissioner's assistants will conduct any market conduct examination.
- 2. Hearings and penalties [Secs. 10-2-804; 10-3-104; 10-3-1107; 10-3-1108; 10-3-1109; 10-3-1111]** The Commissioner may suspend an insurance agency's license if he finds, after a hearing, that any of the agency's partners, officers, or managers knew or should have known of an individual licensee's violation and failed to report it to the Division of Insurance or to take corrective action.
- a. Hearings on unfair trade practices** The Commissioner may conduct a hearing if he believes any person has engaged in an unfair method of competition or an unfair or deceptive act.

b. Cease and desist orders The Commissioner can issue a cease and desist order if, after a hearing, the Commissioner believes the person charged has engaged in an unfair method of competition or an unfair trade practice.

1.) Penalties for Code Infractions [Sec. 10-3-1108] Anyone who has engaged in an unfair method of competition or an unfair trade practice may be fined up to \$1,000 for every violation, up to a maximum total of \$10,000. If the violator is an insurer that knew or should have known that it was violating the law, it may be fined up to \$10,000 for every violation, up to a maximum total of \$150,000 in any six-month period. The Commissioner may suspend or revoke a producer's license if the producer knew or should have known that he was violating the law.

2.) Penalties for Violating Cease and Desist Orders [Sec. 10-3-1109] An insurer that violates a cease and desist order may be subject to a fine of up to \$10,000 for each violation and suspension or revocation of its certificate of authority. A person who violates a cease and desist order may be subject to a fine of up to \$500 for each violation and suspension or revocation of his license.

c. If the Commissioner determines that an unfair trade practice resulted in a failure to pay a claim, the insurer may be liable to pay the claim. The Commissioner determines the proper amount at the hearing.

3. License suspension and revocation [Secs. 10-2-801; 10-2-802; 10-2-803] The Commissioner may suspend, revoke, or refuse to continue, renew, or issue any license if, after notice to the licensee and a hearing, the Commissioner determines that the licensee committed an illegal act. A license is at all times the property of the state of Colorado and must be returned to the Commissioner within 15 days of suspension, revocation, or termination.

a. A license could be suspended or revoked if the license-holder:

- made a false statement in the license application;
- harbored any cause for which the license would have been refused had it existed and had the Commissioner known about it at the time the license was issued;
- violated any insurance law, rule, regulation, or order of the Insurance Commissioner of any state;
- obtained or attempted to obtain a license through misrepresentation or fraud;
- improperly withheld, misused, or converted to his own use (or an applicant's own use) money received in the course of business that belonged to policyholders, insurers, beneficiaries, or others;
- misrepresented the terms of an insurance contract;
- was convicted of a felony or misdemeanor involving moral turpitude (offending justice, honesty, or modesty and otherwise immoral regardless of its illegality);
- committed an unfair trade practice or fraud;

- used fraudulent, coercive, or dishonest practices;
 - acted in an incompetent, untrustworthy, or financially irresponsible manner;
 - had his license suspended or revoked in another state;
 - forged another person's name on an insurance application;
 - failed to meet the licensing requirements; and
 - cheated on a licensing exam.
- b.** The Commissioner may investigate the conduct of any licensee or applicant to determine whether that person has violated state insurance laws or regulations or is engaged in unfair or deceptive acts or practices.
- 1.)** If the Commissioner receives information about a possible violation of insurance law, he may require the alleged violator to show cause why his license should not be revoked, suspended, or denied.
 - 2.)** If the person fails to show such cause, the Commissioner may revoke, suspend, or refuse to issue or renew the license.
- c.** In addition to license denial, suspension, or revocation, a violator may be subject to a civil penalty of up to \$1,000 per violation.
- d. Reporting administrative actions** A producer or insurer must report to the Commissioner any administrative action taken against the producer in another jurisdiction or by another governmental agency in Colorado within 30 days of the action. The report will include copies of any relevant legal documents.
- e. Reporting criminal prosecutions** Within 30 days after the initial pre-trial hearing date, a producer or insurer must report to the Commissioner any criminal prosecution of the producer in any jurisdiction. This report will also include copies of any relevant legal documents.
- For purposes of suspending or revoking a license, a crime of moral turpitude includes any sexual offense against a child. [Sec. 10-2-801(g)(II)]
- f. Transaction of insurance defined** The transaction of insurance includes the following activities:
- Making, or proposing to make, an insurance contract as an insurer
 - Making, or proposing to make, as a guarantor or surety, any contract of guaranty of suretyship as a business
 - Taking or receiving an application for insurance
 - Receiving or collecting premiums, commissions, or other consideration for insurance
 - Issuing or delivering insurance contracts to Colorado residents or to persons authorized to do business in Colorado

- Acting as an agent for or otherwise representing any person or insurer in the solicitation, negotiation, or effectuation of insurance or renewals of insurance; providing information about coverage or rates; inspecting risks and setting rates; or adjusting claims or losses. [Sec. 10-3-903]

Full-time salaried employees of a corporation who manage or buy insurance on behalf of their employer are not transacting insurance. Attorneys who advise their clients about insurance or who adjust claims for their clients are not transacting insurance.

B. LICENSING AND PRODUCERS' LEGAL RESPONSIBILITY

1. **Persons required to be licensed [Secs. 10-2-103(6); 10-2-201; 10-2-401; 10-2-404; 10-2-407; 10-2-408; 10-2-412; 10-2-416; Reg. 1-2-10]** It is illegal for anyone to transact insurance (other than reinsurance or surplus lines insurance) for an insurer that is not authorized to do business in Colorado.

- a. **Insurance producer** Colorado has recently switched to a single-producer system. Rather than separate agent and broker licenses, the state now issues an insurance producer's license.

- 1.) An insurance producer is a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:
 - insurance policies for risks located in Colorado;
 - membership in certain health care prepayment plans; or
 - membership enrollment in certain health care plans.
- 2.) Insurance producers who solicit or negotiate insurance applications on behalf of an insurer represent the insurer and not the insured in any controversy.
- 3.) An insurance producer must be qualified and licensed in any line for which he applies for, procures, or negotiates insurance on behalf of others. An insurance producer may receive qualification for a single license to include one or more of:
 - life;
 - health coverage;
 - life and variable contracts;
 - property;
 - casualty;
 - bail bonds;
 - credit;
 - crop hail;
 - title;
 - surplus lines;
 - travel-ticket-selling;

- health maintenance organizations (HMOs); and
- nonprofits.

4.) Variable contracts A producer applying for a license including variable contracts must prove to the Commissioner that he is registered with FINRA or the United States securities commission and must qualify on the required examination.

5.) General licensing qualifications An individual seeking an insurance producer's license must file an application with the Commissioner and before approving the application, the Commissioner must verify that the applicant:

- is at least 18 years old;
- is competent, trustworthy, and of good moral character and good business reputation;
- is a resident of Colorado or a resident of a state that has a reciprocal agreement with Colorado (if the applicant is a nonresident, the applicant must furnish the Commissioner with a current certification of license status);
- has not committed any act that is grounds for license denial, suspension, or revocation;
- has fulfilled the prelicensing education requirement (unless the applicant is exempt);
- has passed the examination (or satisfied the examination qualification requirements) covering the line or lines of insurance for which the applicant is seeking a license; and
- has paid the required license fee.

6.) Assumed name [Sec. 10-2-701] An insurance producer who uses an assumed name under which he conducts business must register the name with the Commissioner before using it. The Commissioner will not accept registration of the name if it would mislead the public or it is the same or similar name of a producer whose license was revoked or suspended.

b. Insurance agency An insurance agency is a corporation, partnership, association, or other legal entity that transacts insurance business and must obtain an insurance producer's license to transact business in Colorado.

1.) The agency must file an application with the Commissioner who then must verify that the agency has:

- disclosed to the Commissioner the names of all the officers, partners, and directors of the agency (whether they are licensed insurance producers or not);
- officers, partners, and directors who are trustworthy, of good moral character, and of good business reputation;
- paid the required license fee;

- designated a licensed officer, partner, or director to be responsible for the agency's compliance with Colorado's insurance laws and rules;
- registered with the Commissioner the name of each person who, as an officer, director, partner, owner, or member of the agency, is acting as and is licensed as an insurance producer; and
- registered with the Commissioner the name of at least one individual who holds a valid insurance producer's license for the line or lines of insurance requested in the application.

2.) Nonresident agencies must also file a certification of license status with the Commissioner. The Commissioner may require the filing of any documents reasonably necessary to verify the information contained in the application.

c. Limited service licensed provider networks (LSLPNs) [Reg. 2-1-9] are provider networks engaged in the business of insurance and must be licensed as insurance companies. The services provided by the LSLPN must be limited in scope and must be significantly less than the basic health care services offered by a health maintenance organization or under a comprehensive or major medical policy.

1.) These provider networks offer to contract directly with consumers, such as an individual, group, or employer or their representatives, to provide health care services restricted to:

- a narrowly defined health specialty (e.g., substance abuse, radiology, mental health, pediatrics, pharmacology);
- services narrowly limited to a single type of licensed health facility (e.g., inpatient hospital, birth center, long term care facility, hospice); or
- home health care services delivered only in the insured's residence.

2.) Family practitioners, Independent Practice Associations (IPAs) consisting of providers licensed in more than one specialty, or other similar medical/health collaborations, do not meet the definition of a narrowly defined health specialty and, therefore, may not seek licensure under this limited license.

3.) Limited service licensed provider network health coverage plans (LSLPN health coverage plans) are contracts or policies entered into or issued by an LSLPN that agree to assume the risk for specific, limited health care expenses and/or provide for delivery of such services.

4.) An LSLPN license expires on June 30 each year and must be renewed annually. Every license is automatically extended unless the Commissioner refuses to renew the license because the LSLPN no longer complies with applicable regulations.

- d.** No individual or company is allowed to transact insurance business in Colorado without holding the proper license. Insurers must obtain a certificate of authority while producers and agencies must be licensed.
- e. Exception to license requirements [Sec. 10-2-105]** In general, people may not act as insurance producers unless they are licensed as such. However, the following people do not need to be licensed.
- 1.)** Any regular salaried employee of a licensed producer who performs only clerical or administrative services in the employer's office, including the incidental taking of insurance applications, and who does not receive commissions on such applications
 - 2.)** Any regular salaried officer or employee of an insurance company who does not solicit or write insurance and who receives no commission or compensation for business obtained
 - 3.)** Anyone who helps administer group or wholesale life insurance or annuities or group, blanket, or franchise health insurance and who is not paid a commission for this service
 - 4.)** Employers (including their officers and employees) and trustees of any employee trust plan who administer any employee benefit program for their own employees involving insurance issued by a licensed insurer, provided the employees or trustees are not compensated by the insurer
 - 5.)** Employees of insurance companies or organizations hired by an insurance company who are engaging in the inspection, rating, or classification of risks or who are supervising the training of insurance producers and who are not individually engaged in the solicitation or negotiation of insurance policies or contracts
 - 6.)** Management associations, partnerships, or corporations that do not solicit insurance from the public
- f. Fraternal benefit societies** Generally, persons representing fraternal benefit societies who solicit and negotiate insurance contracts are considered insurance producers and are subject to the same licensing requirements as other insurance producers. However, a license is not required of:
- any officer, employee, or secretary of a fraternal benefit society who devotes almost all of his time to activities other than soliciting or negotiating insurance and receives no compensation directly dependent on insurance sales; or

- any agent, representative, or member of a fraternal benefit society who in the preceding calendar year sold life insurance contracts on behalf of any society in the amount of \$50,000 or less (or in the case of any other kind of insurance the society may write, sold life insurance on behalf of 25 or fewer individuals) and received no compensation from these policies, and who does not reasonably expect to sell insurance on behalf of more than 25 individuals in the current year.

g. Prelicensing education Applicants seeking licenses in the life, accident, and health line or the property and casualty line must prove to the Commissioner that they have completed a prelicensing education course or program.

- 1.) An individual seeking an insurance producer's license in life insurance must complete at least 50 hours of an approved course for certification in life insurance; applicants seeking an insurance producer's license for accident and health insurance must complete at least 50 hours for certification in accident and health insurance.
- 2.) An applicant seeking a life and health license must complete 100 hours of prelicensing education.
- 3.) At least three hours of each 50-hour course must cover insurance ethics.
- 4.) Exceptions to the prelicensing education requirement are applicants who are or were licensed in another state, met the prelicensing education requirements of that state, and were exempted in Colorado due to a reciprocal agreement with their home state.

h. Appointment by insurer No insurance producer may claim to be a representative or agent of a particular insurer (or accept applications on behalf of the insurer) unless the producer is appointed by the insurer to act as its agent.

- 1.) This rule does not prohibit a producer from showing the benefits, rates, and features of an insurer's products, even though he has not been appointed by the insurer.
- 2.) Similarly, if a producer is unable to place a risk or policy with the insurer that appointed him, then the producer may attempt to place the risk with another insurer doing the same type of business.
- 3.) Insurers must file with the Commissioner a current list of appointed insurance producers and must notify the Commissioner of any new appointments as well as any appointment terminations.
- 4.) An insurance producer appointment is continued or renewed on October 1 of the year in which the license is renewed.

- 5.) At least 60 days before the appointment expires, the Commissioner will send the appointing insurer a list of those appointments associated with licenses that were continued the preceding January, with an invoice for the required appointment fees.
- 6.) Insurers can at that time renew or terminate appointments. Any appointment that is not continued on or before that date is treated as discontinued.
- 7.) If the appointment is renewed or continued in timely fashion, the appointment remains in effect until the:
 - insurance producer's license is discontinued or cancelled by the insurance producer (or revoked by the Commissioner); or
 - insurer files a notice of termination with the Commissioner.

i. Terminating an appointment When terminating a producer appointment, an insurer must inform the Commissioner within 30 days of the termination. The insurer has an additional 15 days to notify the producer. If the Commissioner requests, the insurer must provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

- 1.) Within 30 days of receiving the notification, the producer may file a written response with the Commissioner and simultaneously send a copy of the comments to the reporting insurer. The comments will become a part of the Commissioner's file and accompany every report about the producer that is sent from the Commissioner's office.
- 2.) **Immunities** In the absence of willful and wanton behavior, an insurer, its representative, a producer, the Commissioner, or any organization to which the Commissioner belongs cannot be sued as a result of any information provided during an investigation of a producer who is being terminated.
- 3.) **Confidentiality** All documents, materials, or other information in the possession of the division of insurance that was furnished by anyone during in an investigation of a producer must be kept confidential.
 - a.) Neither the Commissioner nor any person who received confidential documents or information will be required to testify in any private civil action about the information contained in them.
 - b.) If all parties agree to protect the confidential nature of the documents and material, the Commissioner has the authority to share the information with state, federal, or international regulatory agencies; the NAIC; and state, federal, and international law enforcement authorities. These parties must also agree to keep all information received from the Commissioner's office confidential.

- c.) The Commissioner has the authority to release final disciplinary actions or closed files to public inspection or to a database maintained by the NAIC.
- d.) The Commissioner has the right to disclose any information to any law enforcement agency to use in any criminal or civil investigation or prosecution.
 - This information will not be considered privileged and confidential in any criminal or civil matter, investigation, or prosecution by a government agency, except as provided by regulation.
 - However, any interested party may request the Commissioner not to disclose confidential information if it may cause substantial injury to the public interest.
 - If the Commissioner finds that disclosure will cause such injury, the Commissioner may apply to the district court for an order to restrict the disclosure.

4.) Penalties for failing to report An insurer, its representative, or producer who fails to report as required or is found to have reported with actual malice by a court, may, after notice and hearing, have the producer's license or insurer's certificate of authority suspended or revoked and be fined.

j. Change of address Producers (whether individuals or insurance agencies) must inform the Commissioner in writing of any change in address within 30 days of the change. Failure to do so may result in a fine.

k. License expiration Generally, all producer licenses are renewable biannually, subject to the payment of a renewal fee and completion of continuing education courses, by January 1 after the license is issued.

- 1.) The division of insurance is in the process of converting the renewal date to occur at end of the producer's birth month.
- 2.) If the renewal fee is not paid, the license is not valid.
- 3.) If a producer has paid the fee but not completed the education credits, he may apply for an extension to finish his course work.

2. Payment and acceptance of commissions and fees [Sec. 10-2-702; Reg. 1-2-9] Insurers and producers may not pay fees or commissions for services as an insurance producer to any person who was not properly licensed at the time.

- a. It is illegal for anyone to accept fees or commissions for such services unless they were properly licensed.
- b. Insurance producers may not charge fees in addition to those included in their commissions for soliciting and procuring insurance or for servicing existing policyholders.

- c. Insurance producers may charge fees for specific services (such as financial planning and estate planning) that are beyond their normal duties if:
 - the client signs a proper disclosure statement informing the client that he is not obligated to purchase any insurance product through the producer in exchange for the services; or
 - it is clear from the outset that no insurance product sale related to the services will occur.
- d. Insurance producers must retain a copy of any such disclosure statements for at least three years after completion of the services.
- e. Copies of these statements must be available to the Commissioner upon request.
- f. Insurance producers may not condition the placement of insurance on the provision of other services for which fees may be charged.

3. Fiduciary duties: prohibition against commingling [Sec. 10-2-704; Reg. 1-2-1] A fiduciary responsibility is one of special trust and confidence in which a person is entrusted with the funds of another person.

- a. All premiums belonging to insurers and all unearned premiums belonging to insureds received by a licensee are held in a fiduciary capacity.
 - 1.) A producer may not commingle premiums belonging to insurers and returned premiums belonging to insureds with the producer's personal funds or with any other funds except funds directly related to his business.
- b. All premiums a producer receives, minus authorized commissions, must be remitted to the insurer by the contractual due date or if there is no contractual due date, within 45 days after receipt.
- c. All returned premiums received from insurers or credited by insurers to a producer's account must be credited to the insured's account within 30 days.
- d. If a licensee does not account for a collected premium to the insurer within 45 days after the contractual due date (or 90 days after receipt if there is no contractual due date), the insurer must report this failure to the Commissioner.
- e. An insurer must return unearned premiums to the insured or credit the producer's account as soon as possible after a right of refund is established.
 - 1.) In all cases, this must happen within 45 days.
 - 2.) If a licensee has knowledge of an insurer's failure to remit unearned premiums within 45 days, he must report it to the Commissioner.

- f. Separate accounts** Producers must treat each insurance policy and the premiums received on it as a separate account of the insured.
- 1.) Premiums and refunds that producers receive in connection with a policy may not be credited to any other obligation owed to the producer by the insured unless the insured gives written consent.
 - 2.) When dealing with funds from the insured or insurer, producers must:
 - treat all premiums and return premiums as trust funds and keep them separate from his own funds;
 - keep accurate records of all fiduciary funds;
 - not treat premiums or return premiums as personal or business assets or income on financial statements; and
 - not use fiduciary funds as collateral for personal or business loans, although producers may receive interest on the funds and use them as a compensation balance with the financial institution.
 - 3.) Also, if a producer is going to deposit any premium or returned premium funds into a bank or savings account (until remitting the funds to the insurer or person entitled to the funds), he must use a separate insurance trust account. Any such deposits are subject to Colorado fiduciary law.
- g. Conflict of interest** A conflict of interest arises when a fiduciary is in a position that presents an opportunity for personal interests to clash with the fiduciary's duties to another party. In other words, regard for one duty may lead to disregard of another duty. As a fiduciary of the insurer and the insured, a producer must be careful not to place personal interests above their welfare.
- 4. Continuing education [Sec. 10-2-301; Reg. 1-2-4]** Unless exempt, all producers must complete 24 hours of approved continuing education instruction every two years.
- a. At least 18 of these hours must be in approved courses in the lines of insurance for which the producer is licensed.
 - b. At least three of these hours must be in approved courses in ethics.
 - c. Anyone who holds more than one license only needs to fulfill the requirement once (which must be within 24 months after the date the first license must be renewed).
 - d. For good cause, the Commissioner can grant licensees up to a one-year extension to comply with the requirements.
 - e. Producers can accumulate no more than 12 credit hours to apply to the next continuing education period if the courses are taken within final 120 days of the 24-month license continuation period.

- f.** The continuing education requirements apply to all residents and nonresidents licensed to sell the following types of insurance in Colorado:
 - life insurance and annuity contracts (including variable life and annuity contracts);
 - accident and health insurance;
 - property and casualty insurance; and
 - any other type of insurance for which the state requires a licensing examination.
- g.** The requirements do not apply to:
 - any person holding a license who the Commissioner exempts from the requirements; and
 - a nonresident who complies with the continuing education requirements of his state of residence (if the state of residence has a continuing education reciprocity agreement with Colorado).
- h.** Licensees who fail to comply with the continuing education requirements or who submit false or fraudulent certificates of compliance to the Commissioner will have their licenses suspended until the requirements are met.

5. Unauthorized entities [Sec. 10-3-904.5, 906, 908] The failure of a company transacting insurance business in Colorado to obtain a certificate of authority will not impair the validity of any act or contract of the company and will not prevent the company from defending itself in a court.

- a.** In the event that any unauthorized insurer fails to pay a claim or loss, any person who assists or aids in the procurement of the 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 the insurance contract.
- b.** Anyone investigating or adjusting a loss or claim must immediately report to the Commissioner any policy that has been issued by an insurer not authorized in Colorado.
- c.** Every insurance adviser, counselor, or analyst must report to the Commissioner every insurance policy covering a risk in Colorado that has been issued by an insurer not authorized to transact insurance in Colorado.
- d.** This does not apply to insurance transactions involving a policy lawfully solicited, written, and delivered outside of Colorado, 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 the policy.

e. Emergency cease and desist orders [Secs. 10-3-904.6; 10-3-904.7] The Commissioner may issue an emergency cease and desist order without holding a hearing if:

- he believes that an unauthorized person is engaged in insurance business without being licensed or is in violation of a rule passed by the Commissioner; and
- it appears to the Commissioner that the alleged conduct is:
 - fraudulent,
 - creates an immediate danger to public safety, or
 - is causing or is about to cause significant, imminent, and irreparable public injury.

1.) An unauthorized person is any individual, corporation, association, partnership, or natural or artificial person who transacts insurance business without a license.

a.) If the Commissioner determines that an emergency cease and desist order should be issued, he will serve the order on the person.

b.) The order will contain a statement of the charges and will require the person to immediately cease and desist from the acts, methods, or practices stated in the order.

2.) 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. If, after a hearing, the Commissioner determines that an emergency cease and desist order has been violated, he may:

- impose a civil penalty of \$25,000 for each violation;
- direct the person violating the order to make complete restitution to all state residents, insureds, and entities operating in Colorado that were damaged by the person's actions; or
- impose both a civil penalty and restitution.

3.) If a person fails to pay a penalty or to make complete restitution, the Commissioner may refer the matter to the attorney general for enforcement or may revoke any license, certificate of authority, or other authorization issued to the person.

C. UNFAIR COMPETITION AND DECEPTIVE PRACTICES

1. Boycott, coercion, and intimidation [Secs. 10-3-1104 (1)(d); 10-3-1105]

It is illegal to enter into any agreement to commit an act of boycott, coercion, or intimidation that results in unreasonable restraint or monopoly in the insurance business.

- a. No person may require, as a condition of lending money or extending credit, that the debtor obtain an insurance policy through a particular insurer, agent, or broker.
- b. Neither may a person unreasonably disapprove the insurance policy provided by a debtor for the protection of the property securing the leased property.
- c. No person may require another to pay a separate charge in connection with an insurance policy required as security for a real estate loan.
- d. The Commissioner may investigate any apparent violations and mete out appropriate penalties if a violations is found.

2. Misrepresentation [Secs. 10-3-1104(1)(a)] Insurance producers are expected to represent honestly their policies and the policies against which they compete.

- a. It is illegal to make, issue, circulate, or use any written or oral statement, sales presentation, or comparison that:
 - misrepresents the benefits, advantages, conditions, or terms of any policy;
 - misrepresents the dividends or share of the surplus to be received on any insurance policy;
 - makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;
 - misleads or misrepresents the financial condition of any person or the legal reserve system of a life insurer;
 - uses any name or title of any insurance policy or class of insurance policies that misrepresents its true nature;
 - is a misrepresentation for the purpose of inducing the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;
 - is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; and
 - misrepresents any insurance policy as being a security.
- b. It is not misrepresentation to make a written comparison of policies that factually discloses relevant features and benefits to help a consumer make an informed decision.

3. Unfair discrimination [Secs. 10-3-1104(1)(f); 10-3-1104.5] In Colorado, it is illegal to do any of the following.

- a. Make or permit any unfair discrimination between individuals of the same class and equal life expectancy in the rates, dividends, benefits, or terms of any life or life annuity contract.
- b. Make or permit unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same haz-

ard in the amount of premium, policy fees, or rates charged for any insurance policy or contract or in the benefits, terms, or conditions of the contract.

- c.** Make or permit any classification to be made solely on the basis of marital status or sex, unless the classification is for the purpose of insuring family units or is justified by actuarial statistics.
- d.** Make or permit any classification to be made on the basis of blindness, partial blindness, or a specific physical disability unless the classification is based on an unequal life expectancy or an expected risk of loss that is different from that of other individuals.
- e.** Inquire about or investigate an applicant's, insured's, or beneficiary's sexual orientation in connection with an application for coverage.
- f.** Use information about gender, marital status, medical history, occupation, residential living arrangements, beneficiaries, zip codes, or other territorial designations to determine sexual orientation.
- g.** Use sexual orientation in the underwriting process or in the determination of insurability.
- h.** Make adverse underwriting decisions because an applicant or insured has demonstrated concerns related to AIDS by seeking counseling from health care professionals.
- i.** Make adverse underwriting decisions on the basis of the existence of nonspecific blood code information received from the Medical Information Bureau.
- j.** Reduce benefits under a health insurance policy by adding an exclusionary rider unless the rider excludes only those conditions that have been documented in the original application, medical examination, or medical history of the insured (or that can be shown to have been caused by the medically excluded condition).
- k.** Request or require that an applicant submit to an HIV-related test unless the applicant has given written informed consent and is told about the use of the HIV-related test results and the entities to whom they may be disclosed.

4. Controlled business [Sec. 10-2-401(4)] Insurance written in the licensee's own interests or the interests of his spouse or employer is called **controlled business**.

- a.** A license is deemed to be used for controlled business if, during any 12-month period, the total premiums on controlled business exceed the total premiums on all other business.
- b.** The Commissioner will not grant or renew any license if he discovers it is being used to write controlled business.

- 5. Defamation [Secs. 10-1-116; 10-3-1104(1)(c)]** Making oral or written statements that are false, maliciously critical, or derogatory to the financial condition of an insurer or are intended to injure anyone in the insurance business is known as defamation and is illegal.
- a. Anyone who engages in defamation may be convicted of a misdemeanor punishable by a fine of up to \$500, imprisonment for up to 12 months, or both.
 - b. Every insurer that writes medical malpractice insurance for licensed medical practitioners must send to the Colorado state board of medical examiners all information relating to each medical malpractice claim against a licensed practitioner that is settled or in which a judgment is rendered against the insured.
- 6. Rebates [Sec. 10-3-1104(1)(g)]** Rebating is the practice of giving something of value to a prospective insurance applicant in exchange for the purchase of, or as an inducement to purchase a policy.
- a. In Colorado, rebating is considered an unfair method of competition.
 - b. Illegal inducements to buy policies, as defined by law, include:
 - offering a rebate of premiums;
 - offering any special favor or advantage in the dividends or other benefits of an insurance policy that is not specified in the policy;
 - offering anything of value not specified in the policy;
 - giving, selling, or purchasing any stocks, bonds, or other securities as an inducement to purchase the insurance; and
 - making or offering to make any contract of insurance (or agreement as to such insurance) other than as plainly expressed in the contract.
- 7. Unfair claims practices [Sec. 10-3-1104(1)(h)]** Colorado law protects insurance consumers by clearly identifying certain illegal claim settlement practices.
- a. As a result, it is illegal to:
 - misrepresent provisions of coverage;
 - fail to handle claims promptly;
 - fail to adopt fair standards for investigating claims;
 - refuse to pay claims without conducting investigations;
 - fail to affirm or deny coverage within a reasonable time after submission of proof of loss;
 - fail to achieve a prompt and fair settlement after liability has become reasonably clear;
 - compel insureds to start litigation to recover on claims by offering substantially less than the amount ultimately recovered by legal action;
 - fail to pay claims promptly under one portion of a policy to influence settlement under other portions;
 - settle a claim based on an application that was altered without the insured's consent;

- settle a claim for less than a reasonable person would believe he was entitled to according to the advertising materials accompanying the application;
 - pay or denying a claim without a statement explaining the coverage or laws on which the payment or denial is based;
 - publicize a policy of appealing arbitration awards that are in favor of insureds or claimants in an effort to compel insureds to accept settlements for less than the amount awarded in arbitration;
 - require preliminary claim reports that replicate formal proof of loss forms to delay claim payment; or
 - raise comparative negligence as a defense in a third-party claim without substantial evidence.
- b.** Also, unless there is a reasonable dispute between the insurer and insured, insurers must pay claims under accident and health policies (or property and casualty policies) within 60 days of receiving a valid and complete claim.
- 1.)** If the Commissioner discovers that an insurer has failed to do so, he may order the insurer to pay a monetary penalty to the insured.
 - 2.)** The penalty may not exceed \$20 on claims of \$100 or less; on claims of \$100 or more, the penalty is 8% annual interest on the amount of the claim starting from the date the claim is received until the date the claim is paid.
- c.** In the case of a claim for loss of time for disability, the insured must provide the insurer with written proof of the loss within 90 days after the beginning of the disability period. Subsequent written proofs of loss are to be provided to sustain a claim for continuing disability as often as the insurer may reasonably require. Failure to give this proof within this period does not invalidate the claim if it was not reasonably possible to give the proof within that period and it is given as soon as reasonably possible. However, in all cases other than the absence of the claimant's legal capacity, such proof may not be delayed more than one year.
- d.** The insurer will pay all benefits for loss of time due to disability at least once each month while the disability continues.
- 8. Colorado fraud statute [Secs. 10-1-128; 10-1-129]** In Colorado, a person commits a fraudulent insurance act if he knowingly and with intent to defraud prepares or presents a written statement for the issuance of the rating or for claim of payment which contains false information.
- a.** The state will fight insurance fraud because it is expensive, raises premiums, and places businesses at risk.
 - b.** When an insurance company obtains a judgment or settlement against an insurance producer in an insurance fraud lawsuit, it must notify the state licensing board.

- c. When a person obtains a judgment or settlement in an insurance fraud lawsuit against a producer or insurer licensed by the state of Colorado, it may also notify the state licensing board.
- d. Every licensed insurance company doing business in Colorado (except reinsurance companies) must prepare and follow an insurance anti-fraud plan.
 - 1.) The plan must include specific procedures to prevent, detect, and investigate all forms of insurance fraud, educate employees about the plan, provide for the hiring of one or more fraud investigators, and report insurance fraud to the proper state officials.
 - 2.) All insurance applications, policies, and claim forms must bear a warning against insurance fraud.
- e. The attorney general and the district attorneys of Colorado have concurrent jurisdiction to investigate and prosecute allegations of insurance fraud.

II. COLORADO STATUTES, RULES, AND REGULATIONS PERTINENT TO LIFE INSURANCE ONLY

A. MARKETING AND SALES OF LIFE INSURANCE AND ANNUITY

CONTRACTS [REGS. 4-1-2, -11, -12] Colorado regulates the advertising of life insurance policies and annuity contracts to ensure that all material and relevant information is given to the public.

1. **Advertisements [Reg. 4-1-2]** An insurer is responsible for all advertisements of its policies. It must establish and follow procedures to control the content, form, and method of distribution of its advertisements. It must communicate these methods at least annually to anyone who advertises for the company.

An insurer is to keep a copy of every advertisement used in the state for 5 years after it was last used. These copies are subject to examination by the insurance department.

All advertisements are to be truthful and cannot mislead in fact or implication. The Commissioner determines whether an ad is misleading from the general impression that it can reasonably be expected to create in the mind of a person with average education or intelligence within the targeted audience. In general, ads cannot use “investment,” “investment plan,” “founder’s plan,” “charter plan,” “deposit,” “expansion plan,” “profit,” “profits,” “profit sharing,” “interest plan,” “savings,” “savings plan,” “private pension plan,” “retirement plan,” “risk-free,” or other similar terms. They cannot use the term “vanish” or “vanishing premium” to imply the policy becomes paid up in order to describe a plan using nonguaranteed funds to pay future premiums.

Advertisements must clearly and prominently describe the type of policy advertised. Life insurance policies and annuity contracts are to be labeled as such unless other accompanying documents so label them.

The use of testimonials is limited to genuine statements that represent the current opinion of the author with respect to the policy advertised, if any. They are to

be produced in a manner that does not mislead the public.

Failure to comply with these regulations is an unfair and deceptive trade practice. Violators are subject to license suspension, revocation, or a fine.

- 2. Suitability of annuity purchase or exchange [Reg. 4-1-11]** When recommending the purchase or exchange of an annuity, an insurance company or producer must have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of information obtained from the consumer with respect to his investments, other owned insurance products, and his financial situation and needs.

This information is to be based on the consumer's financial status, tax status, investment objectives, and other relevant information. However, an insurance company or producer has no obligation to a consumer who refuses to give this information, acts contrary to the recommendations of the producer, or fails to provide complete or accurate information. Records of this information are to be kept on file with the insurer for five years and are subject to examination by the Commissioner.

Insurers must supervise producers' recommendations in order to ensure compliance with these regulations.

The Commissioner may order an insurer or producer to take corrective action for any violations of this regulation. Penalties may be reduced or eliminated if corrective measures were taken immediately after the violation. Otherwise, an insurer or producer is subject to a cease and desist order, fine, and suspension or revocation of license.

- 3. Buyer's Guide and disclosure statement [Reg. 4-1-12]** Insurers must send applicants for annuity contracts a disclosure statement and *Buyer's Guide to Fixed Deferred Annuities*.

When the application is taken in person, these documents should be delivered no later than that time. When the application is not taken in person, the documents must be sent no later than five business days after the insurer receives the application. In this case, the applicant must also be notified that he may contact the Division of Insurance for a free annuity *Buyer's Guide*.

If the *Buyer's Guide* and disclosure statement are not given to the applicant by the time the application is taken, the applicant is entitled to a free look period of at least 15 days. This means that the applicant has at least 15 days after receiving the annuity contract to review it and return it for any reason.

The disclosure statement must contain the following:

- a. the generic name of the annuity contract, the company's product name if different from the generic name, the form number, and the fact that the contract is for an annuity;
- b. the insurer's name and address;
- c. a description of the contract and the benefits;
- d. the guaranteed and non-guaranteed elements of the contract, their limitations, if any, and an explanation of how they function;

- e. an explanation of the initial crediting rate, duration of the rate, and how rates can change and are not guaranteed;
- f. periodic income options on a guaranteed and non-guaranteed basis;
- g. value reductions caused by withdrawals from or surrender of the contract;
- h. how the contract values can be determined;
- i. the death benefit, if any, and how it is calculated;
- j. a summary of the federal tax status of the contract and any penalties that apply to withdrawn values;
- k. the effect of any riders on the contract; and
- l. charges and fees that apply to the contract.

Failure to comply with these requirements is an unfair or deceptive act or practice in the transaction of insurance.

B. POLICY REPLACEMENT

1. Replacement forms [Reg. 4-1-4] Replacement occurs when a new policy is written to take the place of a policy already in force. Colorado, like many states, requires producers and insurers to follow strict replacement procedures and each insurer must inform its producers of the need to comply with these procedures.

- a. When a policyowner interrupts one plan of life insurance and begins to build up values in another, he may suffer financial loss.
 - 1.) The new policy often has a higher premium rate based on the insured's attained age.
 - 2.) The policyowner must again pay the initial costs of issuing a policy.
 - 3.) In some cases, replacement may be advisable, but every precaution must be taken to protect the consumer.
- b. The Colorado replacement regulation governs the replacement of life insurance and annuities but does not apply to:
 - credit life insurance;
 - group life insurance or group annuities;
 - life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;
 - contracts issued in connection with employee benefit or welfare plans as defined by ERISA;

- the purchase of additional insurance from the same insurer under a guaranteed insurability provision or other policy privilege;
- short-term (31 days or less) nonrenewable life insurance policies; and
- existing nonconvertible term life policies that expire in five years or less and cannot be renewed.

c. Producer's duties regarding replacement For each life insurance application, the producer must:

- determine if the new policy is replacing an existing policy;
- submit to the insurer a statement signed by the applicant as to whether a transaction involves replacement of existing life insurance or of an annuity; and
- submit to the insurer a signed statement as to whether the producer knows replacement is involved in the transaction.

d. When replacement is involved, the producer must give the applicant, before taking the application, a *Notice Regarding Replacement*.

- 1.) Both the producer and applicant must sign this notice.
- 2.) The producer must also list on the notice all existing life insurance and annuity contracts to be replaced, including the name of the insurer, the insured, and the contract number.
- 3.) The producer must then leave a completed copy of the notice with the applicant and submit a copy with the application.
- 4.) The replacing insurer will keep copies of the notice, statement, any sales material, and the application in the producer's file for that applicant for at least three years.

2. Disclosure [Reg. 4-1-4]

a. The *Notice to the Applicant* shown below must be signed by the producer and the applicant:

- 1.) *Important Notice to Applicant for Life Insurance or an Annuity:*
Replacement is any transaction where, in connection with the purchase of new life insurance or a new annuity, you lapse, surrender, convert, place on extended term, or borrow all or part of the policy loan values on an existing insurance policy or an annuity. In connection with the purchase of this insurance or annuity, if you intend to replace your present life insurance or annuity, you should consider the following.
 - a.) It may be to your advantage to obtain information regarding your existing policies from the insurer or producer from whom you purchased the policy.

b.) *You may be required to provide evidence of insurability for the new policy and:*

- *if the condition of your health has changed since the application was taken on your present policy, you may be required to pay additional premiums under the new policy or be denied coverage;*
- *your present occupation or activities may not be covered or could require additional premiums;*
- *the incontestable and suicide clauses will begin anew in a new policy (this could result in a claim under the new policy being denied that would otherwise have been paid); and*
- *your present insurer is not required to refund any advance premium payments.*

(Note: bullets apply only to life insurance)

c.) *Your present insurer is not required to restore a policy which has been surrendered for cash value or converted or placed on extended term. You may be required to furnish evidence of insurability to reinstate a lapsed life insurance policy. Therefore, you are urged not to terminate or alter your existing policy until you have been issued the new policy, examined it, and found it acceptable.*

b. Statement by applicant Once it is determined that a transaction does involve replacement and an application for the new policy is completed, the producer must present to the applicant a form that allows the insured to state whether he wishes to have his present insurer notified regarding this transaction.

- 1.)** This form must be signed by the applicant and submitted to the insurer along with the application and the notice.
- 2.)** The producer must also submit to the insurer copies of all sales material related to the proposed policy.

3. Recordkeeping of replacements [Reg. 4-1-4] The replacing insurer must maintain copies of the notice regarding replacement, the applicant's statement, and any notifications for at least three years from the initial date of application.

C. GROUP LIFE [SECS. 10-7-106; 10-7-201 THROUGH 207]

1. Exclusive right of insured to proceeds Whenever funds are payable to the beneficiary but are held in trust by the insurer, no one other than the insured has a right to the proceeds.

- a.** Payments of the proceeds are not subject to the insured's debts.
- b.** This provision only applies to policies or contracts in which proceeds are payable on an installment basis; it does not protect proceeds paid in a lump sum.

- c. Neither does it protect funds after they are paid to the beneficiary.

2. Group life Group life insurance policies are often provided by employers for their employees.

- a. Employers include counties, cities, unincorporated towns, school districts, and other political subdivisions in Colorado. These subdivisions may insure employees under group life, accident, and health insurance and may pay the premiums out of the subdivision's revenues.
- b. When employees are required to contribute to the cost of their insurance, deductions may be made from their salaries.
- c. A group life insurance policy may only be issued if the:
 - group exists for a reason other than to obtain insurance;
 - policy covers at least three people on the date of issue; and
 - policy provides that each person eligible for coverage is subject to uniformly applied standards of insurability.
- d. **Mandatory group policy provisions** A group life insurance policy issued in Colorado must contain provisions at least as favorable as:
 - the policyholder must be given a grace period of 31 days for premium payment;
 - once a policy has been in effect for two years, the policy's validity may not be contested except for nonpayment of premiums;
 - all policyholder statements are deemed representations, not warranties, and a copy of the application must be attached to the policy when issued;
 - an equitable adjustment of premiums or benefits must be made upon misstatement of an insured's age;
 - the conditions under which an insurer may require a person to furnish evidence of individual insurability must be specified; and
 - any sum due upon the insured's death is payable to the beneficiary, subject to policy provisions. If there is no beneficiary, the insurer may pay up to \$5,000 to anyone who incurs verifiable funeral expenses.
- e. **Reciprocal provisions** Group policies that are issued by a foreign company (a company formed in a state outside of Colorado) may contain provisions required by the law of the state or territory under which the company is organized.
 - 1.) The policies issued by nonresident companies may contain provisions that are more favorable to employers and employees than are required by Colorado law.
 - 2.) Policies issued in other states or countries by companies organized in Colorado may contain provisions required by the laws of the state, territory, district, or country in which the same types of policies are issued.

- f. Conversion rights for group policies** Each person insured under a group life policy receives an individual certificate specifying the protection provided by the policy and to whom benefits are payable. The certificate must also describe conversion benefits as follows.
- 1.)** If coverage under a group policy ends due to termination of employment or termination of membership in the eligible class, the insurer must issue, without evidence of insurability, an individual life insurance policy (without disability or other supplementary benefits) to the certificate holder, provided that the first premium on the individual policy is paid within 31 days of termination.
 - 2.)** If a group policy terminates the insurance of any class, each certificate holder in that class who has been insured for at least five years before termination is entitled to an individual life insurance policy.
 - 3.)** If an insured under a group policy dies during the period within which the certificate owner would have been entitled to an individual policy and before such individual policy becomes effective, the amount of insurance that the insured would have been entitled to under the individual policy is payable under the group policy.
- g. Issuance and valuation of policies** Any life insurance company may issue life or endowment insurance, with or without annuities, through a group plan with special rates of premiums less than the usual rates of premiums for those policies.
- 1.)** Group policies issued before the 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 may the standard for any such policy be lower than the medico-actuarial table of mortality, or other table of mortality that is approved by the Commissioner, with interest assumption at 3%.
 - 2.)** Group policies issued on or after the date of the Standard Nonforfeiture and Valuation Act must be valued according to the provisions of its regulations.
- h. Annual statement** All group policies must 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, together with the mortality table and interest assumption adopted by the company, must be reported separately in the company's annual financial statement.
- i. Assignment** Nothing in the law prohibits any person insured under a group life insurance policy from assigning all or part of his incidents of ownership, including the privilege to have issued an individual policy and the right to name a beneficiary. Subject to the terms of the policy, such an assignment is

valid for the purpose of vesting in the assignee all of the incidents of ownership, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue before receiving the notice of the assignment.

D. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Many of the basic concepts associated with qualified employer plans can be traced to the Employee Retirement Income Security Act of 1974, commonly called ERISA.

The purpose of ERISA is to protect the rights of workers covered under an employer-sponsored plan.

- 1. Participation standards** All qualified employer plans must comply with minimum participation standards designed to determine employee eligibility. In general, employees who have reached age 21 and have completed one year of service must be allowed to enroll in a qualified plan. Or, if the plan provides for 100% vesting upon participation, they may be required to complete two years of service before enrolling.

- E. SPECIAL OPTIONS** To individual members covered by a group life or group health insurance plan, the function the insurance serves is identical to an individual plan. In the case of group life, should the covered member die, his beneficiary (usually a spouse or children) will receive a stated amount in death proceeds from the group term policy. Thus, the purpose of group life plans is the same as individual life plans.

- 1. Indemnity** As in the case of an individual life insurance policy, a group life insurance policy is a valued contract that pays a stated sum, regardless of the actual loss incurred, when the contingency insured against occurs.
- 2. Accidental Death and Dismemberment** AD&D coverage pays an additional amount when covered employees die or are severely injured by accident. Benefits are stated as a percentage of a principal sum. For example, death caused by a common carrier (such as a scheduled airline) may result in payment of three times the principal sum. For other accidental causes of death, the policy may pay twice the principal sum.
- 3. Waiver of premiums** As in the case of an individual life insurance policy, a group plan may allow its members, for an additional premium, to add a rider that will waive premium payments if members are disabled and unable to pay the group premium.

- F. SUICIDE [SEC. 10-7-109]** After an insurance policy issued in Colorado has been in effect for one year, the insurer may not use an insured's suicide as a reason to refuse payment of policy benefits.

- 1.** The insurer is bound to honor a claim on the policy whether the suicide was voluntary or involuntary and the insured was sane or insane.
- 2.** This rule does not apply to provisions of life insurance policies insuring specifically against accidental death or to any accident policy insuring against accidental death.

G. FREE-LOOK PERIOD [SEC. 10-7-302] Every life insurance policy must contain or be attached to a prominent notice that permits the policyowner to return the policy within 15 days of delivery for a full refund of the premium.

1. The policyowner is entitled to the refund if he is not satisfied with the policy for any reason.
2. The usual free-look period for a life insurance policy that is not delivered as a replacement policy is 15 days.

A life insurance policy must state 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 the insurance laws of the state in which the policy is delivered. It must also explain how the cash surrender values and paid-up nonforfeiture benefits are affected by paid-up additions credited to the policy or any indebtedness to the insurer on the policy.

H. INTEREST ON PROCEEDS [SEC. 10-7-112] Insurers must pay interest on death benefits (at a rate that is not less than the rate of interest on proceeds left on deposit with the insurer and subject to withdrawal on demand for 30 days after the insurer receives a request for payout and proof of death). From that date until the claim is settled, the annual interest rate will be 2% above the federal discount rate, rounded to the nearest full percentage. If the claim is denied and judgment is rendered against the insurer, the annual rate of interest from the date legal action is begun until the claim is paid will be 4% above the federal discount rate, unless the proceeds were left with a court in an interpleader action (to determine rightful ownership of the funds).

1. Any other life insurance policy benefits will accrue interest at a rate of at least 2% above the federal discount rate when the benefits remain unpaid more than 30 days after the insurer receives the insured's request for payment.
2. This rule does not require the insurer to pay interest on the proceeds when the beneficiary chooses, in writing to the insurer, to receive them by any means other than a lump-sum payment.

III. COLORADO STATUTES, RULES, AND REGULATIONS PERTINENT TO SICKNESS AND ACCIDENT INSURANCE ONLY

A. PORTABILITY (CREDIT FOR PREEXISTING CONDITIONS) [SECS. 10-16-102(13.7); 10-16-105; 10-16-118(1)(B); 10-16-214] The insurer may impose a preexisting condition limitation or exclusion period or a carrier waiting period in any health benefit plan. However, the plan must waive any carrier waiting period applicable to a preexisting condition exclusion period if the insured was covered by previous coverage that provided benefits with respect to these services, and this coverage was continuous at least 90 days before the effective date of the new coverage.

1. **Restrictions on preexisting condition limitations** An individual health insurance policy issued in Colorado may not deny, exclude, or limit benefits for an

insured individual because of a preexisting condition for a loss incurred more than 12 months after the effective date of coverage.

- a. The policy cannot define a preexisting condition more restrictively than an injury, illness, or pregnancy for which a person incurred expenses, received medical treatment, consulted a health care professional, or took prescription drugs within 12 months of the effective date of the policy.
- b. All health plans must waive any affiliation or preexisting condition limitation period if the individual was continuously covered up to 90 days before the effective date of new coverage.
- c. The method of crediting and certifying coverage will be determined by the Commissioner.
- d. **Creditable coverage** Creditable coverage means benefits or coverage provided under:
 - Medicare or Medicaid;
 - an employee welfare benefit plan or group health insurance or health benefit plan;
 - an individual health benefit plan;
 - a state health benefits risk pool (including but not limited to CoverColorado); or
 - 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.

2. Maternity and newborn coverage [Sec. 10-16-104(1); (3)]

- a. **Maternity coverage under accident and health policies** Group accident and health policies issued in Colorado to an employer must cover normal pregnancy and childbirth expenses. This rule does not apply to policies purchased by employers that have fewer than 15 full-time employees (or any number of full-time or part-time employees who work less than six consecutive months per year) and who choose to provide coverage via:
 - self-insurance;
 - a policy purchased from an authorized insurer that meets the division's requirements for that purpose; or
 - a combination of the two methods mentioned above.
- 1.) **Coverage for pregnancy** All group accident and health insurance policies must insure against the expense of normal pregnancy and childbirth or cover maternity care in the same manner as any other sickness, injury, disease, or condition otherwise covered by the policy. Policies

may not exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition.

b. Coverage for hospital stay following delivery [Sec. 10-16-104(1); (3)]

Coverage for a hospital stay for a newborn after a normal vaginal delivery cannot be limited to less than 48 hours. If the 48-hour period ends after 8 pm, coverage must continue until 8 am the following morning. Coverage for a hospital stay for a newborn after a cesarean section cannot be limited to less than 96 hours. If the 96-hour period ends after 8 pm, coverage must continue until 8 am the following morning. However, the attending physician and the mother may agree to an earlier discharge, and the mother is not required to remain in the hospital for a fixed period of time following the delivery.

c. Newborn coverage [Sec. 10-16-104(1)] All individual and group accident and health policies that provide coverage on an expense-incurred basis for a family member of the insured must also provide a newborn child with benefits from the moment of birth.

- 1.) The coverage for newborn children must include injury, sickness, treatment for congenital defects, and birth abnormalities.
- 2.) The coverage for newborn children must include any orthodontics or dental care required due to the child being born with a cleft lip and/or cleft palate.
- 3.) If a specific premium must be paid to provide coverage for a child, the insurer may require the insured to submit notification of the birth and payment of the required premium within 31 days after the birth to have the coverage continued beyond the 31-day period.

d. Early intervention services [Sec. 10-16-104(1)] All individual and group accident and health policies issued after January 1, 2008 that include dependent coverage must provide coverage for early intervention services delivered by a qualified early intervention provider to an eligible child.

- 1.) An eligible child is an infant or toddler from birth through two years of age who has significant developmental delays or has a diagnosed physical or mental condition with a high probability of resulting in significant developmental delays.
- 2.) The coverage available annually for each eligible child is \$5,725 (to be adjusted annually), which includes case management costs.

3. Complications of pregnancy [Sec. 10-16-104(2)] Any accident and health policy that provides coverage for disability due to accident or sickness must provide similar coverage for a sickness or disease that is a complication of pregnancy or childbirth. A complication of pregnancy is any disease, disorder, or condition that:

- a. is adversely affected by or caused by pregnancy;
- b. requires physician-prescribed supervision; and
- c. results in a loss or expense that would, if not related to pregnancy, be covered by the policy.

4. Mammography and prostate screenings [Sec. 10-16-104(4) and (10)]

- a. All individual and group accident and health policies issued in Colorado must cover expenses of a mammogram, up to \$60 (adjusted for inflation), according to the age of the insured:
 - a single baseline mammogram for women age 35 to 39;
 - screening at least once every two years for women age 40 to 49 (at least once a year for women with risk factors for breast cancer as determined by a physician); and
 - annual screening for women age 50 to 65.
- b. All individual and group health policies must provide coverage for annual screening for the early detection of prostate cancer in men over the age of 50 and in men over the age of 40 who are in high-risk categories. Such coverage shall be the lesser of \$65 per screening or the actual charge.

5. Diabetes [Sec. 10-16-104(13)] Except for supplemental policies covering specified diseases, all policies must cover diabetes, including equipment, supplies, self-management training, and education. Benefits are subject to the same annual deductibles or copayments established for all other covered benefits, and third-party payors may not reduce or eliminate this coverage.

6. Hospice and home health care offering [Sec. 10-16-104(8); Reg. 4-6-5]

Home health services are services provided by a home health care agency certified by the Colorado Department of Public Health and Environment.

- a. Hospice care services are services provided to the terminally ill under a hospice care program licensed and regulated by the Department of Public Health and Environment.
- b. All individual and group accident and health policies issued in Colorado that provide hospital, surgical, or major medical coverage must offer policyholders the opportunity to purchase home health service and hospice care coverage.

7. Other mandated benefits All individual and group accident and health policies issued in 2009, excluding supplemental policies covering a specified disease or other limited benefit, must also include certain mandated benefits.

- a. Hearing aids for children [Sec. 10-16-104(19)]** Effective January 1, 2009, coverage will include purchase of the following:
- Initial and replacement hearing aids not more frequently than every five years;
 - A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
 - Services and supplies to include initial assessment, fitting, adjustments, and auditory training.
- b. Preventive health care services [Sec. 10-16-104(18)]** Policies issued on or after July 1, 2009 must provide coverage for preventive health care services, which include testing for the early detection of colorectal cancer and adenomatous polyps for average risk adults who are 50 years or older and asymptomatic or those at high risk due to a prior occurrence or other predisposing factor.
- 8. Guaranteed renewability [Sec. 10-16-201.5]** An insurer may only alter or discontinue health coverage under certain circumstances.
- a.** Specifically, an insurer providing coverage under a health benefit plan may only refuse to renew such a plan in the case of:
- nonpayment of the required premium;
 - fraud or intentional misrepresentation of material fact on the part of the plan's sponsor;
 - the carrier is discontinuing coverage of all its similar benefit plans in the state (if so, it must notify all policyholders at least 180 days in advance of nonrenewal and thereafter cannot offer such plans for a period of five years in the state);
 - the Commissioner finds that the continuation of coverage would not be in the best interest of the policyholders, the plan is obsolete or would impair the carrier's ability to meet its contractual obligations (the carrier must provide 90 days notice of discontinuation in such cases);
 - the policyholder of a group health benefit plan fails to comply with participation or contribution rules;
 - a group carrier uses a managed care plan and there is no longer any enrollee in connection with such a plan in the carrier's service area;
 - an employer changes businesses after the effective date of a plan; and
 - an employer ceases to be a member of a bona fide association through which coverage was made available.
- b.** A large group health benefit plan may discontinue offering a particular type of health coverage only if:
- it gives 90 days' notice;
 - it offers the option to purchase any other health insurance coverage it currently offers in the same market; and

- the carrier acts uniformly without regard to past or anticipated claims experience.
- c.** As of January 1, 1999, a carrier may make reasonable modifications to a small group health plan if:
- the modification is effective only upon renewal;
 - the plan is uniformly modified for all groups and individuals;
 - if the plan already provides the state-mandated basic health benefit plan or the standard health benefit plan;
 - 90 days' notice is provided to policyholders and the Commissioner; and
 - the carrier offers the opportunity to purchase any other health plan offered by the carrier in such market.

9. Prompt pay [Secs. 10-16-103.5; 10-16-106.5]

- a. Payment of premiums required in health contracts** Every contract between a carrier and a policyholder must contain a provision that requires a policyholder to pay premiums:
- for each individual covered under the policyholder's policy until the date the policyholder notifies the carrier that the individual is no longer eligible for coverage; or
 - through the date that the policyholder notifies the carrier that the policyholder will no longer maintain coverage for the group.
- 1.)** Premiums will be paid according to the premium payment provisions of the contract.
- b. Prompt payment of health claims** Because patients and health care providers often do not receive the reimbursements to which they are entitled from health insurance entities in a timely manner and because these unnecessary delays represent an drain on health care providers' resources, the legislature has imposed reasonable standards for the timely payment of claims. A policyholder, insured, or provider may submit a claim by:
- United States mail, first class, or by overnight delivery service;
 - email;
 - facsimile (fax); or
 - hand delivery.
- c.** Uncontested claims will be paid, denied, or settled within 30 calendar days after receipt by the carrier if submitted electronically and within 45 calendar days if submitted by other means.
- 1.)** If settling the claim requires additional information, the carrier will, within 30 calendar days of receiving the claim, give the provider, policyholder, insured, or patient a written explanation of what is needed to resolve it.

- 2.) The person receiving a request for more information will submit it within 30 calendar days.
- 3.) The carrier may deny a claim if a provider fails to submit additional information in a timely manner.
- 4.) If the person has provided all additional information necessary to resolve the claim, the claim must be paid, denied, or settled by the carrier within the applicable time period.
- 5.) Except in the case of fraud, all claims must be paid, denied, or settled within 90 calendar days after receipt by the carrier.

10. Utilization review [Secs. 10-16-113, 10-16-113.5; Regs. 4-2-17, 4-2-21] Utilization review is a set of formal techniques designed to evaluate the clinical necessity, appropriateness, or efficiency of health care services, procedures, or settings.

- a. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.
- b. Utilization review also includes reviews to determine whether or not a procedure is experimental or investigational, and reviews of a covered person's medical circumstances to determine if a treatment should be excluded.
- c. **Purpose** The purpose of this regulation is to establish guidelines for insurers in situations involving utilization review. Carriers are required to adopt reasonable standards for the prompt investigation of claims arising from insurance policies; 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; and refrain from denying a claim without conducting a reasonable investigation based on all available information.
- d. Any health plan that base decisions concerning claims on utilization reviews must adhere to these rules.
 - 1.) This does not apply to property and casualty contracts.
 - 2.) Where a decision concerning a claim is in no way based on utilization review, a carrier is not required to use the specific procedures outlined here.
 - 3.) Nothing in this regulation replaces any appeal or due process rights that a person may have under federal or state law.

- e. Procedures for review decisions** A health carrier must keep written procedures for making utilization review decisions and for notifying covered persons and providers acting on behalf of covered persons of its decisions.
- 1.)** A covered person includes the designated representative of a covered person.
 - 2.)** For a prospective review determination, a health carrier must make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure, or service requiring a review determination.
 - 3.)** If a determination cannot be made because the carrier has not received all the information, the carrier must request it in writing, within two working days.
 - a.)** The carrier may allow 20 calendar days to receive the information.
 - b.)** Within two working days of the due date or receipt date, whichever is earlier, the carrier will make a determination based on the available information and provide notification as described below.
- f. Certificate of admission** In the case of certifying an admission, referral, procedure, or service, the carrier will notify the provider providing the service by telephone within one working day of making the initial certification; and will provide written or electronic confirmation of the telephone notification to the covered person and the provider within two working days of making the initial certification.
- g. Adverse determination** In the case of an adverse determination, the carrier must notify the provider providing the service by telephone within one working day of making the decision; and provide written or electronic confirmation of the telephone notification to the covered person and the provider within one working day of making the adverse determination.
- h. Concurrent reviews** For concurrent review determinations, a health carrier must make the determination within one working day of obtaining all necessary information.
- i. Certification of extended stay** In the case of a determination to certify an extended stay or additional services, the carrier must notify by telephone the provider providing the service within one working day of making the certification; and must provide written or electronic confirmation to the covered person and the provider within one working day after the telephone notification.
- 1.)** The written notification must include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

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

j. Retrospective review determinations For retrospective review determinations, a health carrier must make the determination within 30 working days of receiving all necessary information. In the case where a determination cannot be made because the carrier does not receive all information, the carrier must request in writing, within two working days, the additional information.

- 1.) The carrier must allow 20 calendar days to receive the requested information.
- 2.) Within 30 working days of the due date or receipt date, whichever is earlier, the carrier must make a decision based on the available information and provide the notification in the case of:
 - a certification, the carrier will notify the covered person and the provider in writing within five working days of the decision to provide coverage; or
 - an adverse determination, the carrier will notify the provider rendering the service and the covered person in writing within five working days of making the decision.
- 3.) A written notification of an adverse determination must include the:
 - principal reasons for the determination;
 - instructions for initiating an appeal or reconsideration of the determination, including expedited appeals; and
 - instructions for requesting a written statement of the clinical rationale, including the clinical review criteria, used to make that determination to any party who received notice of the adverse determination and who follows the procedures for a request (a carrier must specify that such an appeal process includes a two-level internal review).

k. A health carrier must provide written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. In cases where the provider or a covered person will not release necessary information, the health carrier may deny certification.

l. Emergency services A health carrier may not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent lay person

having average knowledge of health services and medicine and acting reasonably believed that an emergency medical condition or life- or limb-threatening emergency existed.

- 1.) Under these same circumstances, a claim for emergency services necessary to screen and stabilize a covered person may not be denied because the covered person or emergency service provider failed to secure prior authorization.
 - 2.) If care is provided by a noncontracting provider within the service area of a managed care plan, a health carrier may not deny a claim for emergency services and may not require prior authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider.
 - 3.) Health maintenance organizations must also comply with these standards in reviewing claims for emergency services.
- m. Appeals of adverse determinations** A health carrier must establish written procedures for the review of an adverse determination if the time frame of the review would not jeopardize either the life or health of the covered person or the covered person's ability to regain maximum function.
- 1.) This process is a **standard appeal**.
 - 2.) A standard appeal will be available to, and may be initiated by, the covered person or the representative of a covered person.
 - a.) If a health carrier denies a benefit because treatment is an excluded benefit and the claimant provides evidence from a medical or dental professional that there is a reasonable medical basis for not applying the exclusion to the benefit, the denial will be subject to the appeals process.
 - b.) **Two-level internal review necessary** A health coverage plan must specify that an appeal of the denial of a request for covered benefits on the ground that such benefits are not medically necessary, appropriate, or effective must include a two-level internal review. After this internal review, the covered person has the right to request an external review. The carrier will notify the covered person of this right to appeal through a two-level internal review process and that the second level of internal review may be used at the option of the covered person.

A physician who was not involved in the initial adverse decision will evaluate the first-level appeal. A health care professional with appropriate expertise and who was not involved in the initial adverse decision will evaluate the second-level appeal. The covered

person is permitted to attend the second-level review and may have counsel and health care professionals present.

n. Notice and disclosure of right to external review A health insurance carrier must notify a covered person in writing of the person's right to request an external review and include the appropriate information at the time the carrier sends written notice of carrier's final adverse determination.

- 1.) The carrier must include in the required notice a copy of the description of both the standard and expedited external review procedures, including the provisions in the external review procedures that give the covered person or his designated representative the opportunity to submit new information and including any forms used to process an external review.
- 2.) Each carrier must include a description of the external review procedures in or attached to all health coverage plan materials dealing with the plan's grievance procedures including but not limited to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

11. Commission disclosure [Sec. 10-16-133; Reg. 1-2-17] Effective January 1, 2009, an insurance producer who solicits or negotiates an application for health care insurance on behalf of a carrier must disclose to the person purchasing the plan that the insurance producer will receive a commission from the carrier.

- a. The insurance producer will provide the consumer with the standard compensation schedule for the product being sold. The standard compensation can be disclosed as a percentage or fixed amount, depending on how the commission is paid.
- b. Any change to the standard compensation must be disclosed before or at the time of sale.
- c. The producer disclosure requirements only apply to a new policy. After the initial disclosure is made, a disclosure is required only at renewal if the information previously disclosed has substantially changed.
- d. Contingent or additional compensation is not considered standard compensation and does not need to be disclosed.

B. INDIVIDUAL COVERAGE

1. Required provisions [Sec. 10-16-202] The required and optional policy provisions for accident and health insurance policies were presented in detail in a prior unit.

2. Replacement [Reg. 4-2-1] Colorado regulates the replacement of accident and health policies.

- a.** The replacement rules discussed below apply to all health policies except:
- group, blanket, or franchise;
 - accident only;
 - single premium nonrenewable;
 - conversion to another individual or family policy with the same insurer;
 - conversion to an individual or family policy from a group, blanket, or group-type policy;
 - conversion to a Medicare supplement policy to replace a basic or major medical accident and health policy; and
 - Medicare supplement policies covered by their own replacement rules.

b. Rules governing replacement of accident and health policies [10-16-202] Applications for individual accident and health policies must contain a question asking whether the insurance to be issued will replace any other health insurance.

- 1.)** If replacement is taking place, the producer must give the applicant, at the time of application or before the policy is issued, a *Notice Regarding Replacement of Accident and Health Insurance*, which must be signed by the applicant.
- 2.)** The insurer must keep a copy of the signed notice for two years.
- 3.)** This notice, like the notice for replacement of life insurance, is a means of protecting the consumer.
- 4.)** It informs the applicant that:
 - the new policy may not cover current health conditions, which could result in a claim being denied that the current policy may have paid;
 - covered health conditions may be subject to certain waiting periods under the new policy;
 - unless questions in the application are answered truthfully and completely, the policy may not be valid and benefits may not be paid;
 - the new policy will be issued at a higher age than that used for issuance of the present policy, so depending on the benefits, the new policy may cost more than the present policy;
 - the new policy's renewal provisions should be reviewed as it may be advisable to get the present insurer's advice regarding the proposed replacement; and
 - it is important to understand all the factors involved in replacing the present coverage.

- 3. Preexisting condition limitations [Sec. 10-16-118(1)(a)]** A group health insurance plan cannot deny, exclude, or limit benefits for an insured individual because of a preexisting condition for losses incurred more than six months after the effective date of coverage or the first day of the waiting period for enrollment, whichever is earlier.
- a.** The policy can impose a preexisting condition exclusion or limitation only if the exclusion relates to a physical or mental condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within six months before the person's enrollment in the plan or the first day of the waiting period for enrollment, whichever is earlier.
- 4. Sale to self-employed individuals [Secs. 10-16-102, 105.2(1)(c)(I) (A) to (D), (II), (III); Regs. 4-2-19, 4-6-5]** The provisions of the statute concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his employees, together with their dependents, if all of the following conditions are met.
- a.** As part of the application process, the carrier determines whether the applicant is a self-employed person who meets the definition of a business group of one.
- b.** If the applicant is a business group of one self-employed person, the carrier accepts or rejects the self-employed person and, if such person is applying for family coverage, accepts or rejects the entire family unless the applicant waives coverage for a family member who has other coverage in effect.
- If the carrier rejects an application for a business group of one self-employed person and the carrier does business in both the individual and small group markets, the carrier shall notify the applicant of the availability of coverage through the small group market and of the availability of small group coverage through the carrier.
- c.** As part of its application form, an individual carrier requires a business group of one self-employed person purchasing an individual health benefit plan to read and sign a disclosure form stating that, by purchasing an individual policy instead of a small group policy, such person gives up what would otherwise be the right to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three years after the date the individual health benefit plan is purchased, unless a small employer carrier voluntarily permits such person to purchase a business group of one policy within such three-year period.
- d. Business group of one** A business group of one is an individual, a sole proprietor, or a single full-time employee of a subchapter S or C corporation, nonprofit corporation, limited liability company, or partnership who is permanently employed for at least 24 hours per week and who has engaged in significant business activity for at least one year before applying for coverage. A

substantial part of that person's gross income must have been earned through those business activities for at least the last three consecutive years. A "business group of one" also includes a permanent, full-time household employee who works at least 24 hours per week and whose gross income in the last three consecutive years came mostly from such employment if the employer employed at least one household employee on at least half of the days in a normal work week during the preceding calendar year.

- e. Small employer** A small employer is a person or business that, on at least 50% of the working days in the preceding calendar year, employed no more than 50 persons, most of whom were employed in Colorado.
- f. Basic plan** There are three plan design options available to consumers. At least one option must be used in Colorado's small employer group market and as conversion coverage. The other two options must be high-deductible, Health Savings Account qualified plans. If the insurer offers more than one basic health plan, it must offer all of its basic plan options to every small employer who is interested in the basic health plan or to those persons buying a basic conversion plan.
- g. Standard plan** The standard health benefit plan must also be used in Colorado's small employer group market and for use as conversion coverage.

C. GROUP COVERAGE

- 1. Continuation and conversion [Secs. 10-7-202; 10-16-108(1)(a), (b), (c), (d) (XVII), (e), (f)]** When a person's coverage under a group policy providing hospital, surgical, or major medical expense insurance on an expense-incurred basis terminates, and the person was covered for at least three months, a converted policy covering accident and health insurance must be issued without evidence of insurability.
 - a.** The person must apply in writing for the converted policy and pay the first premium within 31 days of termination.
 - b.** The insurer determines the first premium for a converted policy using the rates for the age and class of risk of the person to be covered and the type and amount of insurance provided.
 - c.** Health conditions are not an acceptable basis of classification.
 - d.** The insurer may not require premium payments less frequently than on a quarterly basis unless the insured consents.
 - e.** The converted policy must cover the member and any dependents who were covered by the group policy on the date of termination.

- f. The effective date of the converted policy is the day after termination under the group policy.
- g. The insurer is not required to issue a converted policy to anyone covered by Medicare or by another hospital, surgical, medical or major medical expense insurance policy offering similar benefits.
- h. The conversion privilege is also available to the surviving spouse and children upon death of the covered employee or, if a group policy provides for continuation of dependent coverage following an employee's death, the conversion option must be offered at the end of the continuation period.
- i. Conversion is also offered to the covered employee's spouse and children when their coverage terminates because of divorce. The insurer may provide group coverage to the spouse and children in these cases rather than issuing converted individual policies.
- j. The employee or dependent is allowed 18 months in which to continue individual coverage under the group plan after loss of group coverage, or until the individual becomes eligible for another group plan, whichever occurs first.
- k. A converted policy must offer a choice between a basic or standard health benefit plan. An individual may make this choice provided the group policy has not been terminated, all required premiums or contributions from or on behalf of the individual have been paid and the individual has been covered for at least six months under the group policy.

l. Required provisions in individual accident and sickness policies

If an individual converts coverage from a group policy to individual coverage, the new coverage must include the provisions required for all individual accident and sickness policies issued in Colorado:

- entire contract;
- time limit on certain defenses (incontestability after two years from policy's issue date);
- grace period of at least 10 days for monthly premium policies and 31 days for all other policies;
- reinstatement;
- notice of claim (given to insurer within 20 days after occurrence or beginning of loss);
- claim forms (given to insured within 15 days of notice of claim);
- proof of loss (given to insurer within 90 days of loss);
- time payment of claims (paid upon written proof of loss);
- physical examination and autopsy;
- legal actions (cannot be started within 60 days of written proof of loss or after three years have passed since written proof of loss was provided); and
- change of beneficiary.

- m. Conversion and Medicare [Sec. 10-16-108]** An insurer is not required to issue a converted policy to anyone who is covered by Medicare. Also, an insurer is not required to issue a converted policy to anyone who has or is eligible for similar coverage under another hospital, surgical, medical, major medical expense, or other such policy.
- 2. Maternity [Sec. 10-16-104(3)]** Group accident and health policies issued in Colorado to an employer must cover normal pregnancy and childbirth expenses. This rule does not apply to policies purchased by employers that have fewer than 15 full-time employees (or any number of full-time or part-time employees who work less than six consecutive months per year) and who choose to provide coverage via:
- self-insurance;
 - a policy purchased from an authorized insurer that meets the division's requirements for that purpose; or
 - a combination of the two methods mentioned above.
- a.** Coverage for expenses of normal pregnancy, childbirth, and maternity care must be provided in the same manner as for any other sickness, injury, disease, or condition otherwise covered under the policy. Insurers may not exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition.
- 3. Mental health [Sec. 10-16-104(5)]** Group policies that cover mental illness must provide benefits for at least 45 days of inpatient care or 90 days of partial hospitalization in a psychiatric hospital in any 12-month period.
- a.** For the purpose of computing the benefit period, every two days of partial hospitalization care will count as one day in reducing the 45 days of inpatient care covered.
 - b.** Partial hospitalization means continued treatment for at least three hours but no more than 12 hours in any 24-hour period.
 - c.** Copayment for these benefits cannot exceed 50%.
 - d.** The deductible may not differ from the deductible for any other illness. Aggregate benefits (under major medical) may be limited to \$1,000 per 12-month period.
 - e.** In the case of major medical coverage, benefits cover outpatient services provided by a comprehensive health care service corporation, a hospital, a community mental health center or by a registered nurse, a physician, or psychologist.
 - f.** All services must be supervised by a physician or a psychologist.
 - g.** At least once every 90 days, the physician or psychologist must see the patient, see a summary of consultations or consult with the therapist.

- h.** Any accident and health policy which indemnifies for disability due to sickness and any policy which provides coverage for autism must do so in the same manner as for any other accident or sickness, other than mental illness, otherwise covered by the policy.

4. Alcoholism [Sec. 10-16-104(9)] Each group health policy must offer policyholders the opportunity to purchase coverage for treatment of alcoholism.

- a.** Alcoholism coverage must provide at least 45 days per calendar year of inpatient confinement at a licensed facility that provides services especially for alcoholism treatment.
- b.** Each day of inpatient confinement reduces by one day the total days available for other illnesses during any 12-month benefit period.
- c.** Outpatient benefits must cover services by an accredited hospital, an alcoholism treatment facility or an approved mental health facility for up to \$500 during a 12-month period.
- d.** The copayment for alcoholism treatment may not exceed 50%.
- e.** Benefits are not payable unless the patient completes the full range of care, including detoxification and rehabilitation.

5. Preexisting condition limitation [Sec. 10-16-118(1)(a)] A group health insurance plan cannot deny, exclude, or limit benefits for an insured individual because of a preexisting condition for losses incurred more than six months after the effective date of coverage or the first day of the waiting period for enrollment, whichever is earlier. A converted group policy can only exclude a preexisting condition that is excluded by the group policy.

- a.** Any hospital, surgical, medical, or major medical benefits payable under the converted policy may be reduced by benefits payable under the group policy after the termination of the individual's insurance.
- b.** The benefits of a converted policy may be reduced during the first policy year so that they do not exceed the benefits that would have been payable if the individual's insurance under the group policy had remained in force.
- c.** A group health insurance plan may impose a preexisting condition exclusion only if the exclusion relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before the individual's enrollment date. However, a group health insurance plan may not impose any preexisting condition exclusion relating to pregnancy or a child who is adopted or placed for adoption before reaching 18 years of age.

6. Leasing companies [Sec. 10-16-214(5)] A carrier writing health coverage for an employee leasing company must ensure that any health benefit plan sold to

the 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.

- 7. Late enrollee [Sec. 10-16-102(26)]** A late enrollee is an eligible employee or dependent who wants to enroll in a small employer's benefit plan after the initial enrollment period of at least 30 days has expired.

D. SMALL GROUP COVERAGE

1. Definitions [Secs. 10-16-102, (6), (31), (40); 10-16-105(7); Reg. 4-6-8]

- a. Small employer** In Colorado, a **small employer** is any person, firm, corporation, partnership, or association actively engaged in business that on at least half of its working days during the preceding calendar quarter employed no more than 50 employees, the majority of whom were employed in Colorado.
- 1.)** A small employer includes an individual, sole proprietor, or single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who has been in business for at least one year before applying for coverage and meets certain taxable income requirements.
 - 2.)** It also includes a full-time household employee who works at least 24 hours a week on a permanent basis as a household employee, so long as a substantial part of that person's earned income for the preceding year came from the household employment and the employer retained at least one household employee for most of the preceding three months.
- b. Eligible employee** An eligible employee is an employee who has a regular work week of at least 24 hours.
- c. Business group of one** The definition of a small employer includes a business group of one.
- 1.)** In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.
 - 2.)** This definition can include a sole proprietor or a partner in a partnership if he is included as an employee in a health benefit plan of a small employer. It does not include a temporary or substitute employee.
- d. Premium** A premium is all money paid by a small employer and eligible employees as a condition of receiving coverage from an insurer, including any fees and other contributions associated with a health benefit plan.

2. Guaranteed issue [Secs. 10-8-601.5(1)(a); 10-16-105(7.3)(a), (c)]

Every small employer insurer must actively offer to small employers the choice of a basic health benefit plan or a standard health benefit plan.

- a. The insurer that establishes more than one class of business must offer to eligible small employers at least one basic health plan and at least one standard health benefit plan for each type of plan it offers in the general market.
- b. To determine whether to accept a small employer into a class of business, the insurer may apply criteria that:
 - must not be intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;
 - must be applied consistently to all small employers applying for coverage in the class of business; and
 - provides for the acceptance of all eligible small employers into one or more class of business.

c. Guaranteed renewability A small group health plan must be renewable for all eligible employees and dependents at the option of the small employer.

- 1.) This guarantee is removed for failure to pay premiums, fraud, or misrepresentation by the small employer or the covered individual, failure to comply with plan provisions, an insufficient number of plan participants or substantial change in the nature of the employer's business.

3. Underwriting restrictions [Sec. 10-16-105(7)] A small employer insurer may not request or require from any small group or person applying for coverage medical information going back more than five years from the date of application. It may not use medical information on any of the enrollee members of a small group in underwriting or setting premiums for the group.

4. Rating factors [Sec. 10-16-105(8)(c), (e); (13), (15)] Small employer insurers must apply consistent rating factors with all small employers. The insurer must not use case characteristics other than age, geographic area, and family composition. In addition, it may not use any rating factors other than actual claims experience without prior approval of the Commissioner.

- a. **Premium adjustments** A small employer may be subject to premium adjustments for health status up to 35% above the modified community rate for up to 12 months if the small employer has, during the preceding 12 months, sought health benefit coverage as a small employer, been self-funded, or been insured through a health benefit plan (other than a small group plan), except for health benefit plans sponsored by an employee leasing company. A small employer who has not sponsored health benefit coverage will not be subject to premium adjustments for health status.

5. Participation requirements [Sec. 10-16-102(40)(a); 10-16-105(7.4); (8)(e); Reg. 4-6-8]

- a. The requirements an insurer uses to determine whether to provide coverage to a small employer must be applied uniformly among all small employers applying for or receiving coverage from that carrier.
 - b. The small employer carrier may not use case characteristics other than age, geographic area, and family composition.
6. Basic and standard health plan benefits offered to small employers must include the following provisions.
 - a. **Balance billing** In-network preferred providers and HMO providers cannot balance bill individual insureds. Balance billing is the practice by which a provider bills an individual covered under the basic or standard health benefit plan for the difference between the amount the provider normally charges and the amount the plan sets as the allowable charge for the services rendered.
 - b. **Benefit modifications** The form and level of coverages may be expanded to add coverage through a rider or endorsement only at the policyholder's option.
 - c. **Cost containment** Insurers must disclose whether and to what extent they use the following cost-containment measures:
 - Utilization review
 - Second surgical opinions
 - Preadmission and precertification
 - Nonphysician primary care providers
 - Alternative dispute resolution
 - Managed care
 - d. **Eligibility** Insurers cannot use phrases such as "actively at work" and "nonconfinement."
 - e. **Employer contribution** The insurer can require an employer contribution of no more than 50% of the premium for employee-only coverage. The insurer cannot impose a maximum or minimum employer contribution for dependent coverage. However, employers can choose to contribute more than 50% of the premium for employee coverage.
 - f. **Enrollment of employees and dependents** To enroll employees and dependents, the insurer must require the employer to submit a written request for coverage, provide information needed to determine eligibility, and agree to pay the required premium. Eligible employees must submit a written request for coverage for themselves and any dependents on forms provided by their employer and provide any information needed to determine eligibility.
 - g. **Family planning services** Family planning services are to be included as a covered benefit under the basic and standard health benefit plans. These ser-

vices must include, at a minimum, maternity care, prenatal and postnatal care and counseling, treatment and screening appropriate for sexually transmitted diseases, sterilization, contraceptives, and contraception counseling.

- h. Out-of-pocket maximum** All cost sharing, such as deductibles, coinsurance, and copayments, apply toward the annual out-of-pocket maximum. Once the maximum is reached, the insurer pays benefits at 100%.
- i. Primary care providers** Health plans can use nonphysician providers (such as certified nurse practitioners and physician's assistants) as primary care providers under the basic and standard health benefit plans. Plans are not required to use nonphysician providers.

E. FAIR MARKETING STANDARDS [SEC. 10-16-108.5] Each small employer insurer must actively market health benefit plan coverage to eligible small employers in the state. If an insurer denies coverage to a small employer on the basis of the health status or claims experience of the small employer, the insurer must offer the small employer the opportunity to purchase a basic or standard health benefit plan.

- 1. Prohibited activities** A small employer insurer or producer may not discourage the filing of an application for coverage due to the health status, claims experience, industry, occupation, or geographic location of the individual or small employer. It may also not encourage individuals or small employers to apply for coverage from another insurer due to the health status, claims experience, industry, occupation, or geographic location of the individual or small employer.

F. CREDIT INSURANCE [SEC. 10-10-103; REG. 4-9-2] includes all insurance written in connection with a loan, but does not include insurance written as an isolated transaction by an insurer that is not related to a plan to insure the debtors of a creditor.

- 1. Policy provisions [Sec. 10-10-108]** Each individual credit insurance policy or group certificate of credit insurance must include:
 - a.** The name and home office address of the insurer;
 - b.** The name of the debtor;
 - c.** The premium or amount of payment, if any, by the debtor separately for credit insurance; and
 - d.** A description of the coverage, including the amount and terms, as well as any exceptions, limitations, and restrictions.
- 2. Benefits [Sec. 10-10-108]** The policy should also include a statement to the effect that benefits will be paid to the creditor to reduce or pay off any unpaid debt. If there is any excess insurance after the debt has been paid in full, it will be paid to a beneficiary, other than the creditor, named by the debtor or to his estate.

- 3. Claims procedures [Sec. 10-10-112]** All claims must be promptly reported to the insurer and must be settled as soon as possible. The insurer must maintain adequate claim files. The creditor may not be designated as claim representative for the insurer in adjusting claims.
- 4. Delivery of policy [Sec. 10-10-108]** Upon acceptance of the insurance by the insurer and within 30 days of the date upon which the indebtedness is incurred, the insurer must have the policy delivered to the debtor.

G. SPECIFIED PRODUCTS

- 1. Medicare supplement [Secs. 10-18-101(4); 10-18-103; 10-18-106(1), (2); 10-18-107]** Medicare is part of the Social Security program and provides medical benefits characterized by the payment of deductibles and copayments. Consequently, Medicare does not provide full benefits. To fill the gaps created by Medicare deductibles and copayments, senior citizens may purchase group or individual Medicare supplement policies. Basic Medicare benefits along with a Medicare supplement policy result in more complete coverage.
 - a.** A Medicare supplement policy is a group or individual health policy or a contract with a nonprofit hospital, health service corporation, or health maintenance organization that is marketed or designed as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.
 - b. Benefit standards**
 - 1.)** Medicare supplement policies cannot:
 - indemnify against losses resulting from sickness on a different basis than claims resulting from accidents; or
 - provide for termination of a spouse's coverage solely because of the occurrence of an event specified for termination of the insured's coverage (other than nonpayment of premium).
 - 2.)** Medicare supplement policies must provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors (premiums may be modified to correspond with such changes).
 - 3.)** All Medicare supplement policies must be guaranteed renewable.
 - 4.)** The issuer cannot cancel or refuse to renew the policy:
 - solely on the grounds of the individual's health status or age; or
 - for any reason other than nonpayment of premium or material misrepresentation.

- 5.) If a Medicare supplement policy is terminated by a group policyholder and not replaced, the insurer must offer certificate holders the option to select an individual Medicare supplement policy that provides for:
 - continuation of the benefits contained in the group policy; or
 - benefits that meet the minimum requirements.

 - 6.) If a certificate holder in a group Medicare supplement policy terminates membership in the group, the insurer must offer the certificate holder:
 - an approved conversion opportunity; or
 - continuation of coverage under the group policy, at the option of the group policyholder.

 - 7.) If a policyholder replaces a group Medicare supplement policy with another group Medicare supplement policy, the replacing insurer must offer coverage to everyone who was covered under the old group policy on its date of termination.
 - a.) Coverage under the new policy may not exclude any preexisting conditions that would have been covered under the group policy being replaced.
- c. Preexisting conditions** Medicare supplement policies cannot exclude or limit benefits for losses incurred more than six months from the effective date of coverage because they involved a preexisting condition.
- 1.) The definition of **preexisting condition** cannot be more restrictive than a condition for which medical advice was given or treatment was recommended by a physician within six months before the effective date of coverage.
- d. Minimum benefits** In 1990, as part of the Omnibus Budget Reconciliation Act, Congress required the National Association of Insurance Commissioners (NAIC) to address the subject of Medicare supplement insurance policies.
- 1.) Specifically, this group's task was to develop a standardized model Medicare supplement policy that would provide certain core benefits plus other supplement policies that could be adopted by the states as prototype policies.
 - 2.) The NAIC developed 12 standard Medicare supplement plans, ranging from the basic core policy, with minimum supplemental coverage, to those with more comprehensive coverage. A description of each plan was provided in an earlier unit.
 - a.) No provision of any of the Medicare supplement plans duplicates benefits provided under Medicare.
 - b.) Instead, each plan provides supplemental coverage.

c.) The more benefits a supplement plan offers, the more expensive it will be.

e. **Open enrollment** If an application for a Medicare supplement policy was submitted during the six-month period beginning with the first month in which an individual (age 65 or older) first enrolled for benefits under Medicare Part B, an insurer cannot deny or condition the issuance of a policy or discriminate in the pricing of a policy because of the applicant's health status, claims experience, receipt of health care, or medical condition.

- 1.) All Medicare supplement policies and certificates currently available from an insurer must be made available to all qualified applicants, regardless of age.
- 2.) However, a policy may exclude coverage during its first six months for any preexisting condition that the policyholder or certificate holder received treatment for, or was otherwise diagnosed with, during the six months before the policy became effective.

f. **Disclosure**

- 1.) All riders or endorsements added to a Medicare supplement policy after the date of issue that reduce or eliminate benefits or coverage require a signed acceptance by the insured, except for riders or endorsements:
 - requested by the insured;
 - resulting from the insured's exercise of a specifically reserved right under a Medicare supplement policy; or
 - required to avoid duplication with Medicare.
- 2.) A Medicare supplement policy or certificate cannot provide for payment of benefits based on standards described as usual and customary.
- 3.) Medicare supplement policies and certificates must include a notice informing the insured that he has the right to return the policy or certificate within 30 days after delivery and receive a premium refund if, after examining the policy or certificate, the insured is not satisfied for any reason.
- 4.) At least 30 days before the effective date of any Medicare benefit changes, insurers must notify their insureds of any modifications made to their Medicare supplement policies and the effective date of any premium changes.

g. **Marketing** Colorado has special rules regarding the marketing of Medicare supplement insurance.

- 1.) Outline of coverage** Insurers must provide an outline of coverage to all applicants at the time the application is made. The outline of coverage must include a:

 - description of the principal benefits and coverage;
 - statement of the exceptions, reductions, and limitations;
 - statement of the renewal provisions, including any reservation by the insurer of a right to change premiums; and
 - statement that the outline of coverage is a summary of the policy and that the policy should be consulted to determine governing contractual provisions.
 - 2.) Free-look period** Every Medicare supplement policy must include a prominent notice that allows the purchaser to return the policy within 30 days of delivery for a full refund of the premium.

 - a.)** The purchaser is entitled to the refund if he is not satisfied with the policy for any reason.
 - 3.) Advertising** Every insurer or organization providing Medicare supplement insurance or benefits that advertises such insurance must provide the Commissioner with a written copy of the advertisement.

 - a.)** If there is a complaint about a radio or television advertisement, the Commissioner may request an audio or video cassette from the insurer.
 - 4.) Excessive insurance** In recommending the purchase or replacement of Medicare supplement insurance, producers must make reasonable efforts to determine whether the purchase or replacement is appropriate.

 - a.)** Any sale of Medicare supplement coverage that will provide an individual with more than one Medicare supplement policy or certificate is prohibited.
- h. Penalties [Sec. 10-18-109]** In addition to other applicable penalties for violations of the insurance rules, the Commissioner can order violators to cease marketing any Medicare supplement policies or certificates in Colorado. He can also order violators to comply with the law.
- 2. Long-term care [Sec. 10-19-101 through 115; Reg. 4-4-1]** A long-term care insurance policy is a group or individual policy that provides coverage for at least 12 months for necessary diagnostic, preventive, therapeutic, rehabilitative, or custodial services in a setting other than an acute care unit of a hospital.

a. Marketing standards

- 1.) Insurers who market long-term care policies in Colorado must:
 - establish marketing procedures that ensure its producers will fairly and accurately compare policies;
 - establish marketing procedures that ensure its producers will not sell excessive insurance, or cause it to be issued;
 - clearly and obviously display on the first page of the outline of coverage the following:
 - **Notice to buyer** *This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations and:*
 - *reasonably try to determine whether a prospective applicant for long-term care insurance already has accident and health or long-term care insurance, and the types and amounts of such coverage;*
 - *establish auditable procedures that ensure compliance with these marketing standards; and*
 - *give written notice to the prospective applicant at the time of solicitation that a senior insurance counseling program approved by the Commissioner is available, and provide the name, address, and telephone number of the program.*
- 2.) In addition to the marketing practices that are generally prohibited in the solicitation or sale of any life and health insurance policy, producers who sell long-term care policies may not engage in the following.
 - a.) **Twisting** This is the misrepresentation of insurance policies or insurers for the purpose of inducing a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to purchase a policy from another insurer.
 - b.) **High pressure tactics** These are marketing methods that effectively induce the purchase of insurance through force, fright, threat, or undue pressure.
 - c.) **Cold lead advertising** This is any marketing method that fails to conspicuously disclose that a purpose of the method is the solicitation of insurance and that an insurance company or producer will contact the prospect.

b. Disclosure requirements

- 1.) All prospective applicants for long-term care policies must receive an outline of coverage at the time of initial solicitation that includes a:
 - description of the policy benefits and coverage;

- statement of the policy's principal exclusions, reductions, and limitations;
 - statement of the renewal provisions, including whether the insurer reserves the right to change premiums; and
 - statement that the outline of coverage is a summary of the policy issued or applied for.
- 2.)** A shopper's guide for long-term care insurance must also be given to prospective applicants.
- a.)** The time at which an applicant must receive the outline of coverage and the shopper's guide depends on how the applicant is solicited.
- If the solicitation is made through direct response methods, the applicant must receive these items when the application is given.
 - If the solicitation is made through individual means, these items must be given to the applicant before the application.
- 3.) Policy Summary** A producer must provide a *Policy Summary* when he delivers a long-term care policy to a policyholder.
- a.)** In a direct response solicitation, the insurer delivers the *Policy Summary* upon the applicant's request, but regardless of the request, must provide the summary no later than at the time the policy is delivered.
- b.)** The *Policy Summary* should contain:
- an explanation of how long-term care benefits interact with other parts of the policy, including deductions from death benefits;
 - an illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for every covered person; any exclusions, reductions, and limitations of benefits; and
 - if applicable, a disclosure of the effects of exercising other rights under the policy, a disclosure of guarantees related to long-term care costs of insurance charges, and current and projected maximum lifetime benefits.
- 4.) Underwriting disclosures** Every application for long-term care insurance, except those which are guaranteed issue, must include clear and simple questions intended to determine the applicant's state of health.

- a.) For instance, the application must inquire whether the applicant has been prescribed medication, and if so, what medication has been prescribed.
 - b.) Unless a policy is guaranteed issue, the applicant should be made aware that incorrect and untrue answers to questions on the application are grounds for rescission and denial of benefits.
 - c.) A copy of the completed application or enrollment form is delivered to the insured no later than at the time the policy or certificate is delivered.
 - d.) The insurer is to maintain a record of all policy or certificate rescissions, except those which the insured initiated. This record is reported to the Insurance Commissioner every year.
- c. Free-look period** A purchaser of an individual long-term care insurance policy has the right to return it within 30 days of delivery for a full refund of the premium if he is not satisfied with it for any reason.
- d. Long-term care renewability** Long-term care insurance policies issued to individuals cannot contain renewal provisions that are less favorable to the insured than guaranteed renewable provisions (unless nonrenewal is authorized by the Commissioner on a statewide basis to protect the interests of insureds).
- 1.) The term *guaranteed renewable* can only be used when the:
 - insured has the right to continue the policy in force by the timely payment of premiums; and
 - insurer has no unilateral right to refuse to renew the policy or change any policy provision while the insurance is in force (though the insurer can revise rates on a class basis).
 - 2.) Insurers may also offer noncancellable policies.
 - a.) As far as renewability is concerned, a noncancellable policy is the same as a guaranteed renewable policy except that the insurer cannot revise rates on a class basis for a noncancellable policy.
- e. Incontestability period** If a long-term care policy has been in force for less than six months, an insurer may rescind the policy or deny a claim under the policy if it can show that it issued the policy upon a material misrepresentation of the insured.
- 1.) If the policy has been in force for at least six months but less than two years, an insurer may rescind the policy or deny a claim under the policy if it can show that it issued the policy upon a material misrepresentation of the insured and that the misrepresentation relates to the basis for the claim.

2.) Misrepresentation alone, however, is not a sufficient basis to contest a policy that has been in force for two or more years. The insured must have knowingly and intentionally misrepresented relevant facts concerning his health before the insurer may contest the policy.

f. Benefit triggers A long-term care insurance policy must pay benefits on the basis of the insured's ability to perform **activities of daily living (ADLs)** and on cognitive impairment.

1.) A policy cannot condition payment on a more restrictive basis than requiring either a deficiency in the ability to perform not more than three ADLs or a cognitive impairment.

2.) A policy must include at least five of the following activities of daily living:

a.) Bathing The ability to wash oneself by sponge bath, or in a tub or shower, including the tasks of getting into or out of the tub or shower.

b.) Continence The ability to maintain control of bowel and bladder functions, or, when unable to maintain such control, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

c.) Dressing The ability to put on or take off all items of clothing and any necessary braces, fasteners, or artificial limbs.

d.) Eating The ability to feed oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube, or intravenously.

e.) Toileting The ability to get to and from the toilet, get on or off the toilet, and perform associated personal hygiene.

f.) Transferring The ability to move in and out of a bed, chair, or wheelchair.

3.) Insurers may use ADLs to trigger covered benefits in addition to those listed above, as long as they are defined in the policy. In any case, these other benefit triggers cannot restrict or substitute for the ADLs listed above.

4.) What constitutes a deficiency for purposes of triggering a benefit?

- a.) A policy may not define deficiency any more restrictively than:
 - the need for hands-on assistance of another person to perform the ADL; or
 - if the deficiency is caused by a cognitive impairment, the need for supervision or verbal cuing by another person to protect the insured or others.

- b.) Licensed or certified professionals (such as physicians, nurses, and social workers) are qualified to determine whether an insured is physically impaired in any ADL or suffering from a cognitive impairment.

g. Limitations and exclusions In general, long-term care insurance policies issued in Colorado cannot limit or exclude coverage by type of illness, treatment, medical condition, or accident.

- 1.) However, the following limitations and exclusions are permitted:
 - preexisting conditions or diseases;
 - mental or nervous disorders (however, Alzheimer's disease, senile dementia, and other organic brain syndromes or senility diseases cannot be excluded or limited);
 - treatment provided in a government facility (unless otherwise required by law) when there are no charges for services;
 - services for which benefits are available under Medicare or another governmental program (except Medicaid or any other program required by law), federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
 - services provided by a member of the covered person's immediate family; and
 - services for which no charge is normally made in the absence of insurance.

- 2.) A long-term care insurance policy may not:
 - be terminated on the basis of the insured's age or deterioration of mental or physical health;
 - contain a provision that requires a new waiting period if existing coverage is converted to or replaced by a new policy within the same company, unless the insured chooses to increase benefits;
 - cover only skilled nursing care or provide significantly more coverage for skilled care in a facility than for lower levels of care; or
 - exclude coverage for Alzheimer's disease, senile dementia, or other organic brain syndromes or diseases.

- 3.) If a long-term care policy provides benefits for home health care services, it cannot limit or exclude benefits by:
 - requiring that the insured receive skilled care in a nursing facility if home health care services are not provided;
 - requiring that the insured first or simultaneously receive nursing care, therapeutic services, or both in a home or community setting before the policy will cover home health care services;
 - limiting eligible services to those provided by a registered or licensed practical nurse;
 - requiring that a nurse or therapist render services that can be provided by a home health aide or other certified home care worker;
 - requiring that the insured have an acute condition before the policy will cover home health care services; or
 - limiting benefits to services provided by Medicare-certified agencies or providers.
 - 4.) Insurers that offer a home health care benefit in a long-term care policy must provide for at least 40 home health care visits.
 - 5.) A long-term care policy may not require the insured to be hospitalized before it pays benefits.
 - a.) Furthermore, no policy may condition eligibility for benefits in an institutional care setting on the receipt of a higher level of institutional care.
 - b.) A home health care policy cannot require that an insured be institutionalized before it pays benefits.
 - c.) Otherwise, a long-term care policy may condition eligibility for noninstitutional benefits on the receipt of prior institutional care, so long as the policy does not require a stay of longer than 30 days in the institution.
- h. Extension of benefits** If a policy is terminated while the insured is institutionalized, the insurer may not stop paying benefits as long as the institutionalization continues without interruption.
- 1.) The insurer may limit the extension to the duration of the benefit period, if any, or to payment of the maximum benefits under the policy.
 - 2.) It may also be subject to any waiting period and other applicable terms of the policy.
- i. Continuation or conversion of long-term care insurance** Group long-term care insurance in Colorado must provide covered individuals with a basis for continuation of coverage or conversion to an individual policy with

similar benefits (without evidence of insurability) when the policy would otherwise terminate.

- 1.) The insurer must receive the written application for a converted policy and the first premium within 31 days after termination of coverage under the group policy.
 - 2.) The premium for the converted policy must be calculated according to the insured's age at the inception of coverage under the original policy.
 - 3.) Continuation of coverage or issuance of a converted policy is mandatory unless:
 - coverage was terminated because the individual failed to pay the required premium when due; or
 - the terminating coverage is replaced with another policy that provides similar benefits within 31 days after termination.
 - 4.) A basis for conversion of coverage is a policy provision that entitles an insured to issuance of a converted policy from the group insurer without evidence of insurability.
 - a.) The insured's coverage under the group policy would otherwise terminate or has been terminated, and the individual must have been continuously insured under the group policy for at least six months before termination.
 - b.) Dependents are entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.
- j. Required disclosure provisions** All riders or endorsements added to an individual long-term care insurance policy after the date of issue that reduce or eliminate benefits or coverage require signed acceptance by the individual insured (except for riders or endorsements requested in writing by the insured under an individual long-term care insurance policy).
- 1.) A long-term care insurance policy that pays benefits based on standards described as usual and customary must explain those terms in the outline of coverage.
 - 2.) Long-term care policies must also include the following provisions.
 - a.) **Renewability** This provision must clearly state the duration of renewability, if it is limited, and the duration of the coverage issued.
 - b.) **Limitations** Any conditions or limitations with respect to preexisting conditions must be placed in a separate paragraph of the policy or certificate and labeled as *Preexisting Condition Limitations*.

k. Inflation protection requirement All insurers that offer long-term care insurance policies must also offer policyholders the option to purchase a policy that increases benefit levels as the cost of long-term care services increases because of inflation. The inflation protection option must be at least as favorable as one that:

- increases benefit levels annually;
- guarantees the insured the right to increase benefit levels periodically without providing evidence of insurability or health status (as long as the option for the previous period has not been declined); or
- covers a specified percentage of actual or reasonable charges.

l. Replacement requirements Long-term care insurance application forms must ask whether the proposed insurance policy is intended to replace any other accident and health or long-term care insurance policy presently in force.

- 1.) If the sale will involve replacement, the insurer must furnish the applicant with a *Notice Regarding Replacement of Accident and Health or Long-Term Care Coverage*.
 - a.) One copy must be retained by the applicant.
 - b.) Another copy must be signed by the applicant and retained by the insurer.
- 2.) As with the outline of coverage and the shopper's guide, the timing of the notice depends on the method of solicitation.
 - a.) If the applicant is solicited by direct response methods, the notice must be given when the policy is issued.
 - b.) If the applicant is solicited by other means, the notice must be given before the policy is issued.
- 3.) Insurers must maintain records of all replacement sales and total sales of long-term care policies.
 - a.) In addition, they are to track their producers' replacement sales and total sales.
 - b.) They must account for lapses of long-term care insurance policies sold by their agents and compare them with agents' total annual sales.
 - c.) They report this information to the Division of Insurance by June 30 every year.
- 4.) These reported replacement and lapse rates do not alone show a violation of insurance laws or imply wrongful activity.

- a.) The reports allow insurers to closely review agent activities when selling long-term care insurance.
- m. Acceleration of death benefits** When a long-term benefit becomes payable by the acceleration of a death benefit, the insurer must inform the policyholder of any long-term benefits paid out during the month and provide an explanation of any changes in benefits caused by the acceleration of a death benefit.
- 1.) Life insurers who offer an accelerated death benefit for long-term care must file a cost disclosure illustration with the Insurance Division.
 - 2.) This illustration states the charges for the life insurance policy and the accelerated death benefit provided for either in the policy or by rider, and the manner in which the insurer applied the charges.
 - 3.) A cost disclosure illustration must accompany the outline of coverage when the insurer delivers it to the prospective applicant for review.
- n. Anti-lapse protection** Long-term care insurers must offer policyholders the opportunity to designate an individual who can be contacted in the event the policy is about to lapse.
- 1.) If the policyholder refuses, the carrier must obtain a written waiver.
 - 2.) If the policy lapses due to nonpayment of premium by a policyholder with a cognitive impairment, the carrier must provide a 90-day reinstatement period.
- o. Preexisting condition limitations** A long-term care policy can designate a condition as preexisting only if advice or treatment was received from a health care provider within six months preceding the effective date of coverage.
- p. Requirement to offer basic and standard long-term care plans** Every carrier who offers long-term care insurance to Colorado residents must offer a choice of a basic or standard long-term care plan in addition to any other plan offered by the carrier.
- 1.) This requirement does not apply to individual and group annuities of life insurance policies that provide or supplement long-term care insurance by accelerating benefits.
 - 2.) An insurer specifically identifies the basic and standard health benefit plans by name and type.
 - a.) For instance, the insurer titles the basic plan as *Basic Nursing Home Long-Term Care Insurance Plan for Colorado*.

- b.)** Similarly, the standard plan is titled *Standard Nursing Home/Home Care Long-Term Care Insurance Plan for Colorado*.
- c.)** When an insurer markets these plans to small employers, it must use at least the same methods of distribution that it uses to market other health benefit plans to these employers.
- 3.)** The plans must, at a minimum, provide:
- an elimination period of no more than 60 days that can be imposed only once during the term of the policy;
 - inflation protection that increases the previous year's daily maximum benefit and total plan benefit by 5% on each anniversary starting with the second year (applicants may reject this provision on the application);
 - benefit payments after the elimination period;
 - benefit triggers that condition the payment of benefits on a determination that the insured is a chronically ill individual;
 - nursing home benefits that are paid for qualified, skilled, intermediate, or custodial levels of care in a state-licensed institution;
 - a waiver of premium during nursing home stays once the insured has been eligible for nursing home benefits for 90 consecutive days; and
 - bed reservation benefit that reserves the insured's accommodations in a nursing home facility for up to 21 days while he is hospitalized during the policy year.
- 4.)** In addition, a basic plan must include a nursing home benefit that provides \$100 per day at issue for a benefit duration of 1,095 days.
- 5.)** A standard plan must contain a maximum benefit amount of \$125,000 at issue, which can be applied to any of the covered care settings, at the insured's discretion.
- 6.)** A standard plan also includes a nursing home benefit of \$100 per day at issue, and a home health care benefit equal to 50% of the daily nursing home benefit.
- 7.)** The mandated minimum form and level of coverage can be expanded to add increased coverage, such as additional service settings, longer benefit durations, and higher payment levels, through a rider or endorsement at the policyholder's option.
- a.)** An insurer must distinguish clearly the basic and standard long-term care insurance benefit plans from the benefits and costs that may be added by a rider.

- 8.) The mandatory provisions of the basic or standard long-term care plans may never be lessened by rider, endorsement, or otherwise at the time of sale.
 - a.) The buyer may, at his sole discretion, reduce coverage no earlier than 180 days after buying the policy.
 - 9.) Both plans must contain provisions that qualify the buyer to receive any tax deduction under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
 - q. **Penalties** Any carrier or producer who violates Colorado law regulating long-term care insurance is subject to a fine of up to three times the amount of commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.
 - 1.) This fine is in addition to other disciplinary measures available under the Colorado insurance statutes, including issuance of cease and desist orders, suspensions or revocations of licenses, or any combination of these penalties.
 - r. **Continuing education requirement [Sec. 10-19-113.6]** No one may sell or transact long-term care insurance without being licensed as an insurance producer for accident, health, sickness, or life insurance. Furthermore, the producer must complete a one-time training course on or before January 1, 2009, with continuing education every 24 months thereafter. The one-time training course must be at least 16 hours of classroom education, eight of which must focus on long-term care in general, and the other eight on long-term care partnership plans. The continuing education course must consist of at least five hours of classroom education. Topics are to cover long-term care insurance, long-term care services, and, if applicable, qualified state long-term care insurance partnership programs.
- 3. Basic and standard plans [Secs. 10-16-102; 10-16-105(7.2)(b); Reg. 4-6-5; Sec. (III) (A through L) and policy requirements section (pp. 1-4)]** Every carrier of basic and standard health benefit plans required for use in Colorado's guaranteed issue program for small employers must actively market the plans to small employers in the state.
- a. In doing so, the carrier is to use the same sources and methods of distribution it uses to market other health benefit plans to small employers.
 - b. The following disclosure statement, prominently displayed in bold type capital letters no smaller than 14 point for printed materials or in a clear and conspicuous manner for printed materials, electronic, or Internet communications, must appear on all small employer marketing materials, application forms, and renewal notices, and on all written refusals to insure that are related to health coverage for a business group of one.

- 1.) Colorado insurance law requires all carriers in the small group market to issue any health benefit plan it markets in Colorado to small employers of 2 to 50 employees, including a basic or standard health benefit plan, upon the request of a small employer to the entire small group, regardless of the health status of any of the individuals in the group. Business groups of one cannot be rejected under a basic or standard health benefit plan during open enrollment periods as specified by law.
 - 2.) **Employer contributions** A carrier may not require a maximum employer contribution of more than 50% of the premium for employee-only coverage. A carrier may not impose a maximum or minimum employer contribution for dependent coverage. Employers may choose to make a contribution on behalf of dependents and may decide to pay more than 50% of the premium for employee coverage.
- c. The requirements for the application process cannot be more stringent than those applied to other health benefit plans the carrier offers.
 - d. If a small employer carrier denies coverage to a small employer for any of its health benefit plans on the basis of risk characteristic, the denial must be in writing and specify the reasons for the denial. It must accompany a written explanation of the availability of the basic and standard health benefit plans from the carrier.
 - e. The carrier may not condition the sale of a basic or standard health benefit plan on the small employer's purchase of any other product or service.
 - f. A carrier may also not compel the small employer to replace an existing plan with a basic or standard health benefit plan.
 - g. Carriers can determine whether they are acting as small employer carriers in the sale of individual or group health coverages by obtaining the following information from applicants whether:
 - any part of the premium will be paid by or for a small employer;
 - the prospective insured will treat the health benefit plan as part of an employee benefits program, cafeteria plan, trade, or business expense or contribution to a medical savings account as employer-provided coverage; and
 - the health coverage was marketed through the employer's place of business.
 - h. **Coverage** The mandatory mental health coverage provision does not apply to any small employer that has not provided group accident and health insurance to employees after July 1, 1989.
 - 1.) However, any small employer that is not required to provide mental health coverage must be offered the opportunity to purchase the coverage.

- 2.)** If a small group accident and health insurer elects not to provide mandatory coverage provisions, the insurer must disclose to the insured the services and benefits that are not covered and the estimated amount of premium reduced by eliminating such coverage.

 - a.)** The disclosure notice must be given in writing to all interested policyholders and certificate holders (as part of the sales and marketing materials) before the insurer approves the application for insurance.
- 3.)** A small group health insurance plan or policy must be renewable to all eligible employees and dependents at the option of the employer, except when:

 - required premiums have not been paid;
 - the employer or insured individual is guilty of fraud or misrepresentation;
 - there is noncompliance with plan provisions;
 - an insufficient number of individuals under the plan meet the plan's percentage requirements; or
 - the employer is no longer actively engaged in the business that it was engaged in on the effective date of the plan.
- 4.)** A small group accident and health insurer subject to these provisions may cease to renew all plans under a class of business.
- 5.)** At least 90 days before termination of coverage, the insurer must provide notice to all affected health insurance plans and to the Commissioner in each state in which an affected insured individual is known to reside.
- 6.)** An insurer or other entity that exercises its right not to renew all plans in a class of business shall not:

 - establish a new class of business for a period of five years after the nonrenewal of the plans without the Commissioner's prior approval; or
 - transfer or provide coverage to any of the employers from the nonrenewed class of business, unless the insurer offers to transfer or provide coverage to all affected employers, eligible employees and dependents without regard to case characteristic, claim experience, health status, or duration of coverage.
- 7.)** Small group accident and health insurers must disclose the following information in solicitation and sales materials provided to small employers:

- the extent to which premium rates for specific employees are established or adjusted because of the experience, health status, or duration of coverage of the small employer's employees or their dependents;
- the provisions regarding the insurer's right to change premium rates and the factors (including case characteristics) that affect changes in premium rates;
- a description of the class of business in which the small employer is or will be included, including the applicable grouping of plans; and
- the provisions relating to renewability of coverage.

8.) Each small group health insurer must maintain at its principal place of business a detailed description of its rating practices and renewal underwriting practices.

9.) An individual, corporation, association, partnership, or other entity engaged in the health insurance business may not request from a small group applying for coverage (or from an individual in a small group applying for coverage) medical information from more than five years before the application date.

4. Benefit description plan [Sec. 10-16-108.5(11); Reg. 4-2-20] Since January 1, 1998, all carriers of health benefit plans or Medicare supplemental coverage have been required to make available a Colorado health benefit plan description form for every policy, contract, and plan.

- a.** This form is standardized and is designed to facilitate comparison of different health benefit plans.
- b.** The carrier must ensure that the form is given to any person requesting it within three days.
- c.** If a small employer carrier offers a health benefit plan with a deductible of at least \$1,500, the carrier must disclose to each covered person the amount of the deductible and any copayments, deductibles, and cost-sharing arrangements. [Sec. 10-16-105]
- d.** A small employer carrier cannot alter an employer's or employee's basic or standard health benefit plan through a rider, endorsement, or other means if the effect of the modification is to limit or exclude coverage for certain diseases or medical conditions that the plan otherwise covers. [Sec. 10-16-105]

H. COVERCOLORADO [SECS. 10-8-501, 10-8-513, 10-16-105.5] The Colorado High Risk Health Insurance Act was passed to provide access to health insurance for Colorado residents who are deemed uninsurable because they are unable to secure health insurance or can only obtain it at prohibitive expense or with restrictive exclusions.

1. This act created **CoverColorado**, the program that administers the benefits.
2. To be eligible for the plan, a person must be a resident of Colorado or of the United States for at least six months and must be able to prove that he applied for health insurance and the application was:
 - rejected because of the applicant's health or medical condition;
 - accepted, but at a premium rate exceeding the rate available through the plan; or
 - accepted with a reduction or exclusion of coverage for a preexisting medical or health condition for more than six months.
3. A person also qualifies for the plan if his health insurance coverage was terminated by an insurer for any reason other than a failure to pay premiums.
4. The plan provides a maximum benefit of \$1 million for any one person's lifetime.
5. The following individuals shall not be eligible for coverage under the program:
 - those who are eligible for health care services under the Colorado Medical Assistance Act;
 - those who fail to pay any program premium when due;
 - those whose coverage under the program has been terminated less than 12 months prior to the date of the current application;
 - those who have received \$1 million in benefits from the program;
 - those who are inmates or residents of public institutions;
 - those who are eligible for any other health benefit plan, including any public program, that provides coverage for health care services; and
 - those for whom the payment premiums are paid or reimbursed, directly or indirectly, under any public program; by any federal, state, or local government agency or political subdivision; or by any private entity or person, including a health care professional, health care facility, other health care provider, or pharmaceutical company, if any such payer could financially benefit from the coverage of an individual under the program.
6. Dependents of participants may be covered under the program, but the program need not offer the same health benefit plan or same premium to such dependent as is offered to eligible individuals.
7. The residency requirement shall be waived for any individual who has been a participant in a program similar to CoverColorado in another state and who, within 30 days of relocating to this state, applies for coverage under the program.
8. Notwithstanding any provision of this section to the contrary, an individual shall not lose eligibility for the program solely because a member of the individual's family pays, in whole or in part, the premiums for the program.

- 9. Preexisting Conditions [Sec. 10-8-516]** Coverage under the CoverColorado program can exclude expenses incurred during the first six months of coverage for any preexisting condition that is defined not more restrictively than an injury, sickness, or pregnancy for which a person incurred expenses, received medical treatment, sought health care services, or took prescription drugs within the six months immediately preceding the effective date of coverage. Credit must be given for the time a person had qualifying previous coverage for the preexisting condition that was continuous to a date not more than 90 days before the effective date of enrollment in the program. Similarly, the program cannot exclude coverage for a preexisting condition if the person had coverage for at least a three-month continuous period not more than 90 days before enrolling in the program.
- 10. Adverse Underwriting Decisions and Notice to Persons Affected [Reg. 4-6-3]** If an insurance company rejects an application for insurance, it is required to notify the applicant or insured that he may be eligible for coverage under CoverColorado. Dependents are also eligible for coverage under the program. Adverse underwriting decisions that trigger this notice are:
- rejection of the application due to the applicant's medical condition or history;
 - acceptance of the application but at a premium that exceeds the rate available through CoverColorado; or
 - acceptance of the application but only with reduced, limited, or restrictive riders or exclusion of coverage for a preexisting condition for longer than six months.
- 11. Penalties for Unfair or Deceptive Acts and Practices [Sec. 10-3-1108]** If the Commissioner, after due notice and hearing, finds that an insurer has violated the insurance code or engaged in an unfair practice or deceptive method of competition while engaged in the CoverColorado program, the Commissioner may:
- issue an order to cease and desist;
 - impose a fine of up to \$3,000 for each act or violation, not to exceed a total of \$30,000;
 - impose a fine of up to \$30,000 for each willful act or violation, not to exceed a total of \$750,000 for the year;
 - suspend or revoke the insurer's certificate of authority for a willful violation;
 - order payment of a contractual claim to an insured or beneficiary if the violation was the reason why the claim was not paid; or
 - order any combination of the above penalties.

COLORADO LAW SUPPLEMENT PRACTICE FINAL

Student instructions: Following your thorough study of this supplement, take this 50-question sample examination. Grade your performance utilizing the answer key provided. Carefully review the topics pertaining to those questions answered incorrectly.

I. General Insurance

1. What is the maximum amount the Commissioner can fine an insurer for each willful violation of a cease and desist order?
 - A. \$500
 - B. \$1,000
 - C. \$5,000
 - D. \$10,000
2. When appropriate, the Commissioner reports a violation of insurance law to
 - A. an appropriate district attorney
 - B. the state police
 - C. the attorney general
 - D. the state legislature
3. An alien insurance company is organized in a
 - A. state other than Colorado
 - B. country other than the United States
 - C. state with a reciprocal agreement with Colorado
 - D. country other than the United States with a reciprocal agreement with Colorado
4. An insurer that terminates a producer's appointment must inform the Commissioner within how many days?
 - A. 15
 - B. 30
 - C. 45
 - D. 60
5. All of the following are duties of the Commissioner EXCEPT
 - A. keeping records of the insurers that he has examined
 - B. adopting rules and regulations
 - C. writing insurance laws
 - D. submitting an annual report to the general assembly
6. When an insurer terminates a producer's appointment, the insurer must notify
 - A. the Attorney General and the Commissioner
 - B. all of the producer's policyowners
 - C. the Commissioner and producer
 - D. all of the above
7. An insurance producer who solicits insurance on behalf of an insurer represents the
 - A. insurer
 - B. insured
 - C. beneficiary
 - D. Commissioner's office
8. The Commissioner may
 - A. conduct investigations relating to insurance matters only through the state Attorney General
 - B. conduct investigations on his own but cannot subpoena witnesses
 - C. investigate only individuals and companies that apply for licenses
 - D. conduct investigations and subpoena witnesses whenever he deems it necessary
9. The Commissioner gives approval to an insurer to do business in Colorado in a certificate of
 - A. convenience
 - B. authority
 - C. admittance
 - D. agency
10. In Colorado, all of the following are considered unfair trade practices EXCEPT
 - A. misrepresentation
 - B. rebating
 - C. replacement
 - D. coercion

11. All of the following are violations of Colorado insurance law EXCEPT
 - A. charging individuals of the same class different premium rates
 - B. offering tickets to a football game as an incentive to purchase a policy
 - C. informing a new policyholder that his new policy, if lapsed for nonpayment of premium, could be reinstated upon reapplication
 - D. having an arrangement to sell stock to a person contingent upon the purchase of an annuity
12. All of the following insurance practices are illegal in Colorado EXCEPT
 - A. soliciting or procuring insurance without a license
 - B. paying a fee for services as an insurance producer to anyone who is not properly licensed
 - C. inquiring about an applicant's sexual orientation in connection with an application
 - D. replacing one life insurance policy with another
13. How many hours of continuing education must be in courses associated with the lines of insurance for which the producer is licensed?
 - A. 10
 - B. 14
 - C. 15
 - D. 18
14. All of the following are examples of unfair claim settlement practices EXCEPT
 - A. requiring both a claimant and his physician to fill out extensive proof of loss forms
 - B. denying a claim promptly but without explaining the coverage or laws on which the denial is based
 - C. paying a claim promptly but without explaining the coverage or laws on which the payment is based
 - D. denying a claim without making an investigation
15. A producer has how many days to file a written appeal to the Commissioner after he has been terminated by his appointing insurer?
 - A. 15
 - B. 30
 - C. 60
 - D. 90
16. A fraternal benefit society may sell life or accident and health insurance to
 - A. Colorado residents only
 - B. the general public
 - C. those who need low-cost insurance coverage
 - D. members of the fraternal society only
17. To be licensed to sell life, accident, and health insurance in Colorado, an applicant must complete
 - A. 20 hours of prelicensing education in both life and health insurance, for a total of 40 hours
 - B. 40 hours of prelicensing education
 - C. 80 hours of prelicensing education
 - D. 100 hours of prelicensing education
18. A fiduciary responsibility is defined as
 - A. the responsibility the producer has to the appointing insurer
 - B. the responsibility of the insured to pay premiums in a timely fashion
 - C. a relationship of special trust and confidence when a person is entrusted with another's funds
 - D. the relationship between the broker and the insurer whose products are sold
19. A producer who was to write a majority of his insurance business on the employees and officers of a restaurant owned by his wife is transacting
 - A. controlled business
 - B. family business
 - C. closely-held insurance business
 - D. reciprocal business

20. Circulation of a maliciously critical statement about an insurer's financial condition to damage the insurer's reputation or business is called
- A. conservation
 - B. unfair discrimination
 - C. defamation
 - D. coercion
21. In general, people who represent fraternal benefit societies to solicit insurance are
- A. exempt from licensing requirements because they serve a limited market
 - B. considered personal representatives of the society rather than insurance producers
 - C. considered insurance producers and must meet all licensing requirements
 - D. classified as financial services representatives
22. How must insurance producers account for each insurance policy and the premiums they receive on it?
- A. As part of their total book of business
 - B. As a separate account owned and controlled by the producer
 - C. As part of the issuing insurer's general fund
 - D. As a separate account of the insured
23. Suppose a producer helps a client set up an estate plan, which is not part of the producer's usual service. The producer can charge a fee for this service under all of the following circumstances EXCEPT
- A. when it is clear from the beginning that no sale of an insurance product is related to the service
 - B. when the client signs a disclosure statement which stipulates that he is not obligated to buy insurance from the producer in exchange for the service
 - C. when the producer always planned to sell insurance to the client
 - D. when the financial service is beyond the producer's normal duties
24. Which of the following policyholders may request that the Commissioner examine an insurer because they fear the insurer is unsound or insolvent?
- A. At least 100 policyholders who have called the Commissioner's office with requests for an examination
 - B. One policyholder with at least \$1 million insurance in force
 - C. At least 5 policyholders who have at least \$100,000 insurance in force and who have specified their concerns in writing
 - D. A significant percentage, to be determined by the Commissioner, who have serious complaints about the insurers' market and claims practices

II. Life Insurance

25. To be valid, a group life insurance policy
- A. must be issued to a group formed solely for the purpose of obtaining insurance
 - B. must cover at least three people
 - C. may not extend coverage to dependents
 - D. may not subject individuals to standards of insurability
26. The usual free look period for a life insurance policy that is not delivered as a replacement policy is how many days?
- A. 10
 - B. 15
 - C. 20
 - D. 30
27. A group life policy is incontestable (except for nonpayment of premium) once it has been in effect for
- A. 6 months
 - B. 1 year
 - C. 2 years
 - D. 3 years
28. A group life insurance policyholder must be given a grace period for premium payment of how many days?
- A. 14
 - B. 15
 - C. 30
 - D. 31
29. Which of the following statements regarding the *Notice Regarding Replacement of Life Insurance* is CORRECT?
- A. It is presented to the applicant only on request.
 - B. It must be presented to the applicant after the policy is issued.
 - C. A copy of the notice must be signed by the applicant and submitted with the application.
 - D. A copy of the notice must be reviewed and signed by both the policy applicant and beneficiary.
30. Which of the following potential insurance sales would be subject to replacement regulations?
- A. A new policy issued by the same insurer as part of a conversion option
 - B. A new policy that causes an existing life insurance policy to be surrendered
 - C. A credit life insurance policy that causes an existing credit life insurance policy to be forfeited
 - D. A new annuity that is constructed differently than the one currently owned by the annuitant
31. If a producer offers to refund part of a prospect's premium in exchange for the purchase of a life insurance policy, the producer is committing the illegal act of
- A. rebating
 - B. defamation
 - C. twisting
 - D. conservation
32. Which of the following is not a problem when existing life insurance is replaced with new coverage?
- A. The risk that a financial loss will occur when values in the existing policy end and new values are built in new coverage.
 - B. Comprehensive coverage may increase under the new policy.
 - C. The new policy may be based on the insured's attained age, with higher premiums than existing coverage.
 - D. The policyowner may pay additional costs for the new policy to issue.

III. Accident and Health Insurance

33. When an employee's coverage terminates under a group health policy, the employee must be offered continuation coverage for
- 60 days
 - 180 days
 - 365 days
 - 18 months
34. Accident and health policies that provide coverage on an expense-incurred basis for a family member of the insured
- must cover only those family members covered at the time the policy is issued
 - must cover a newborn child from the moment of birth
 - may exclude sickness from a newborn's coverage
 - must require notice to the insurer of the birth of a newborn before coverage is provided
35. An accident and health policy whose premiums are paid on a quarterly basis must contain a grace period of at least how many days?
- 15
 - 31
 - 45
 - 60
36. Which of the following coverage exclusions or limitations is permitted under a long-term care policy issued in Colorado?
- Preexisting conditions
 - Alzheimer's disease
 - Senile dementia
 - Parkinson's disease
37. Under a coordination of benefits (COB) provision, the group health plan most likely to be considered the primary plan is the one that
- has been in effect the longest
 - covers the insured as an employee or member
 - covers the insured as a dependent
 - has the lowest deductible
38. All accident and health policies issued in Colorado that provide major medical services must offer policyholders the opportunity to purchase
- disability coverage
 - double indemnity coverage
 - home health care coverage
 - supplemental coverage
39. An insurer providing group health coverage may not be required to issue a converted policy to
- anyone covered by Medicare
 - anyone not covered by a Medicare supplement policy
 - anyone whose coverage ended because of layoffs
 - dependents whose coverage ended because of divorce
40. Which of the following statements about a Medicare supplement policy is CORRECT?
- The insurer may cancel it on the grounds of the insured's health status alone.
 - The insurer may cancel it because the insured has not paid the premiums.
 - It can indemnify against losses resulting from sickness on a different basis from claims resulting from accidents.
 - The insurer may cancel it on the grounds of the insured's geographic location.
41. An insurance policy that increases benefits to keep up with anticipated cost increases for long-term care services is said to have
- inflation protection
 - guaranteed benefits
 - Medicare supplemental protection
 - loss of income protection
42. How often must an individual accident and health insurance policy pay for the mammograms of a 56-year-old Colorado woman?
- Once every year
 - Once every 2 years
 - Once every 5 years
 - Coverage for mammography is not mandated for women over the age of 55

43. Suppose that an insurance producer urges an elderly applicant to buy a second Medicare supplement policy “just to be sure” all potential medical expenses are covered. This sale is
- A. mandatory because high medical costs are almost never fully covered by Medicare and only one supplement
 - B. advisable because medical costs for the elderly can drain a fixed income
 - C. discretionary because the applicant already has several levels of coverage for health care costs
 - D. prohibited because the sale of a supplement which will provide the person with more than one Medicare supplement is illegal
44. Long-term care policies can limit or exclude coverage for all of the following circumstances EXCEPT
- A. preexisting conditions or diseases
 - B. family history of heart condition before the effective date of coverage
 - C. treatment provided in a government facility which is not required by law
 - D. services provided by a member of the insured’s family
45. What accident and health insurance renewability clause means the insurer cannot unilaterally change any provision while the policy is in force but can change premium rates by class?
- A. Noncancellable
 - B. Guaranteed renewable
 - C. Provisional
 - D. Transitional
46. To be eligible for health insurance through the CoverColorado plan, an individual must be all of the following EXCEPT
- A. financially insolvent
 - B. a resident of Colorado for the last 6 months
 - C. rejected for insurance because of health conditions
 - D. accepted by an insurer but charged a premium rate greater than what is available through the plan
47. The CoverColorado plan provides an insured with a lifetime maximum benefit of
- A. \$50,000
 - B. \$100,000
 - C. \$1,000,000
 - D. \$1,500,000
48. How many days is the free-look period for a purchaser of a long-term care insurance policy?
- A. 10
 - B. 30
 - C. 60
 - D. 90
49. An insurer can deny a claim under a long-term care insurance policy if it has been in effect for
- A. fewer than 6 months
 - B. more than 6 months
 - C. at least 1 year
 - D. no more than 2 years
50. Under what condition may an insurer refuse benefits to the beneficiary of an insured who committed suicide?
- A. It can prove that the insured was insane.
 - B. It can prove that the insured’s suicide was voluntary.
 - C. The insured committed suicide within two years of the policy’s effective date.
 - D. The insured committed suicide within the first year of the policy’s effective date.

ANSWERS TO COLORADO LAW PRACTICE FINAL

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|--------------|--------------|--------------|--------------|--------------|
| 1. D | 11. C | 21. C | 31. A | 41. A |
| 2. A | 12. D | 22. D | 32. B | 42. A |
| 3. B | 13. D | 23. C | 33. D | 43. D |
| 4. B | 14. A | 24. C | 34. B | 44. B |
| 5. C | 15. B | 25. B | 35. B | 45. B |
| 6. C | 16. D | 26. B | 36. A | 46. A |
| 7. A | 17. D | 27. C | 37. B | 47. C |
| 8. D | 18. C | 28. D | 38. C | 48. B |
| 9. B | 19. A | 29. C | 39. A | 49. A |
| 10. C | 20. C | 30. B | 40. B | 50. D |