

# INSURANCE

## Regulatory Changes

**HB 10-1166** (Enacted)  
Plain Language in Insurance Policies

**HB 10-1203** (Enacted)  
Group Life Insurance Minimum  
No Requirement

**HB 10-1227** (Enacted)  
Medical Malpractice Insurance Sales

**HB 10-1394** (Enacted)  
Professional Construction Insurance

**SB 10-049** (Enacted)  
Liability Limits Life Health Insurance  
Protection

**SB 10-076** (Enacted)  
Unreasonable Insurance Claims  
Practices

## Workers' Compensation

**HB 10-1009** (Enacted)  
Pinnacol Assurance Board  
of Directors

**HB 10-1012** (Postponed Indefinitely)  
Limit Surveillance Workers' Comp  
Claims

**HB 10-1038** (Enacted)  
Workers' Comp Claims Process  
Brochure

**HB 10-1109** (Enacted)  
Inmate Work Program  
Workers' Comp

**HB 10-1247** (Enacted)  
Sunset Work Comp Class  
Appeals Board

**HB 10-1356** (Postponed Indefinitely)  
Workers' Comp Policyholder  
Protection Act

**SB 10-011** (Enacted)  
Workers' Compensation Conflicts  
of Interest

**SB 10-012** (Enacted)  
Workers' Comp Benefits Knowing  
Penalty

**SB 10-013** (Enacted)  
Workers' Compensation Accountability

**SB 10-112** (Enacted)  
Workers' Compensation Insurance  
Rate Setting

**SB 10-163** (Enacted)  
Workers' Compensation Procedures

**SB 10-178** (Enacted)  
Fair Workers' Comp Provider Reviews

**SB 10-187** (Enacted)  
Workers' Comp Act  
Various Provisions

## Health Insurance

**HB 10-1004** (Enacted)  
Standardized Health Insurance  
Information

**HB 10-1008** (Enacted)  
No Gender Rating for Individual  
Health Insurance

**HB 10-1021** (Enacted)  
Required Coverage for  
Reproductive Services

**HB 10-1103** (Postponed Indefinitely)  
Catastrophic Illness Fund for Children

**HB 10-1154** (Postponed Indefinitely)  
Mandates Analysis Legislative  
Council Moratorium

**HB 10-1160** (Enacted)  
Wellness Incentives Reward Outcomes

**HB 10-1163** (Postponed Indefinitely)  
Interstate Purchase of Health  
Insurance

**HB 10-1166** (Enacted)  
Plain Language in Insurance Policies

**HB 10-1202** (Enacted)  
Insurance Coverage Chemotherapy  
Treatment

**HB 10-1242** (Enacted)  
Uniform Individual Health Insurance  
Application

**HB 10-1252** (Enacted)  
Breast Cancer Screening with  
Mammography

**HB 10-1266** (Postponed Indefinitely)  
Health Insurance for Local Governments  
and Small Businesses

**HB 10-1330** (Enacted)  
All-payer Health Claims Database

**HB 10-1332** (Enacted)  
Medical Clean Claims

**HB 10-1355** (Enacted)  
Off-label Use of Cancer Drugs

**SB 10-076** (Enacted)  
Unreasonable Insurance Claims  
Practice

**SB 10-183** (Enacted)  
Extend the Prohibition on Medical  
Balance Billing

## Regulatory Changes

The General Assembly considered several bills relating to the regulatory structure of insurance. **House Bill 10-1166** requires that the coverage documents for insurance policies and plans issued or renewed on or after January 1, 2012, be written at or below a 10th-grade reading level. For policies and plans longer than 3 pages or 3,000 words, the text must be written in 10 point or larger type and contain an index or table of contents. Insurance companies are required to report readability scores as part of their annual filings with the Division of Insurance in the Department of Regulatory Agencies. The bill requires the Commissioner of Insurance to promulgate rules regarding the electronic dissemination of policy forms or endorsements. The policies and plans impacted by the bill's requirements include:

- private passenger automobile insurance;
- health benefit plans;
- limited benefit health insurance;
- dental plans; and
- long-term care plans.

Current law establishes the minimum number of persons that must be covered under a group life insurance policy as three. **House Bill 10-1203** removes the minimum number requirement.

**House Bill 10-1227** allows approved nonadmitted (not licensed in Colorado) insurers to sell professional liability insurance coverage to physicians, dentists, and health care institutions who are unable to secure coverage from admitted (licensed) insurers. This coverage must meet the minimum financial responsibility requirements for an individual or institution to be licensed or authorized to practice health and dental care in Colorado. The bill further specifies that a health care institution must furnish evidence to the Department of Public Health and Environment that the Commissioner of Insurance has accepted and approved an alternative form of establishing financial responsibility if the health care institution:

- does not have a commercial professional liability insurance policy, or
- the limits of professional liability insurance coverage are in excess of any self-insured retention amount, or
- there is a deductible.

The Colorado Court of Appeals ruled in 2009 that complaints in construction defect cases that only allege poor workmanship do not meet the definition of an occurrence that triggers a duty to defend in a commercial general liability policy (CGL).<sup>1</sup> For the purposes of guiding pending and future actions in interpreting liability insurance policies issued to construction professionals,

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<sup>1</sup>*General Security Indemnity Company of Arizona v. Mountain States Mutual Casualty Company*

**House Bill 10-1394** clarifies the state's policy as follows:

- in interpreting a liability insurance policy issued to a construction professional, a court shall presume that the work of a construction professional that results in property damage is an accident unless the property damage is intended and expected by the insured;
- upon a finding of ambiguity in an insurance policy, a court may consider a construction professional's objective, reasonable expectations in the interpretation of an insurance policy issued to a construction professional;
- if an insurance policy provision that appears to grant or restore coverage conflicts with an insurance policy provision that appears to exclude or limit coverage, the court shall construe the insurance policy to favor coverage if reasonably and objectively possible;
- if an insurer disclaims or limits coverage under a liability insurance policy issued to a construction professional, the insurer shall bear the burden of providing a preponderance of the evidence that the policy bars or limits coverage for legal liability and any exception to the limitation, exclusion, or condition in the policy does not restore coverage under the policy; and
- an insurer's duty to defend a construction professional or other insured under a liability insurance policy shall be triggered by a potentially covered liability.

**Senate Bill 10-049** concerns the Colorado Life and Health Insurance Protection Association (LHIPA). The LHIPA is a statutory organization made up of about 1,000 member companies from the life and health insurance industry that are licensed to sell annuities, life, or health insurance products in Colorado. The LHIPA charges annual fees to its members and can assess members following a member insolvency. The bill increases the benefit liability limits the LHIPA can pay to an eligible person whose insurer — an association member — becomes insolvent and unable to pay benefits. The limits for annuities and structured settlement annuities are increased from \$100,000 to \$250,000 and long-term care benefits are increased from \$100,000 to \$300,000. The LHIPA's aggregate liability limits per person are unchanged.

Addressing unfair claims practices, **Senate Bill 10-076** prohibits an insurance company from providing a financial incentive to a person to influence the person's decision to deny or delay a claim, or to cancel or rescind an insurance policy.

## **Workers' Compensation**

In the 2010 legislative session, a number of bills addressed workers' compensation procedures and Pinnacol Assurance, a provider of workers' compensation insurance and a political subdivision of the state. Several bills were recommended by the 2009 Interim Committee to Study Issues Related to Pinnacol Assurance. Among those bills was **House Bill 10-1038**, which requires an employer or the employer's insurance carrier to provide a brochure, developed by director of the

Division of Workers' Compensation in the Department of Labor and Employment after consultation with affected parties, to each workers' compensation claimant. The brochure will include contact information, a description of the claims process, and information on a claimant's rights to medical treatment and benefit payments under workers' compensation law.

The interim committee also recommended **Senate Bill 10-011**, which makes several changes to workers' compensation law concerning conflicts of interest by physicians, insurers, and employers. The bill requires physicians who provide independent medical examinations to provide a summary disclosure of any business, financial, employment, or advisory relationships with an insurer or self-insured employer upon request. The bill prohibits the payment or receipt of a financial incentive to encourage the delay or denial of a workers' compensation claim. In addition, the bill requires that if an injured worker is not present for communications between a treating physician and the employer or insurer, the treating physician will provide a written record of the communications to the injured worker. Finally, the bill prohibits the inclusion of reversionary interests in indemnity benefits in a workers' compensation insurance contract. This prohibition prevents an insurer from receiving the remaining value of an annuity upon the death of an injured worker. Such a provision, including those in an existing contract, is void and unenforceable.

Also recommended by the interim committee was **Senate Bill 10-012**, which increases the maximum penalty for violating workers' compensation laws from \$500 to \$1,000 per day of violation. The director of the Division of Workers' Compensation or an administrative law judge will apportion at least 50 percent of the penalties to the aggrieved party, with the remainder going to the Workers' Compensation Cash Fund. The bill also changes the standard for determining when benefits are wrongfully withheld by an insurer or self-insured employer from acting "willfully" to "knowingly." Under current law, 75 percent of a penalty is paid to the injured worker and 25 percent to the Subsequent Injury Fund.

The interim committee also put forth **Senate Bill 10-013**, which requires workers' compensation insurers to survey a limited number of injured workers and to report survey findings annually to the Division of Workers' Compensation. The bill includes protections against retaliation for responding to the survey. The division must post the survey results on its website and must also post the procedures for an injured worker to file a complaint with the division. In addition, the bill requires Pinnacol Assurance to submit an annual report to the Governor and to the General Assembly on its business operations, resources, and liabilities.

The interim committee also recommended changes to the workings of the Pinnacol Assurance board in **House Bill 10-1009**, which requires public notice at least seven days prior to a Pinnacol Assurance board hearing.

Finally, the interim committee recommended two bills that were postponed indefinitely. As introduced, **House Bill 10-1012** would have prohibited surveillance of an injured employee who submitted a workers' compensation claim unless the insurer or employer had a reasonable basis to suspect an injured employee had committed fraud or made a material misstatement concerning a claim. The bill would have allowed an injured employee who discovered he or she is under surveillance to request an expedited hearing before a prehearing administrative law judge who could have issued an injunction against the surveillance. The bill also would have required the insurer or employer to provide all materials collected during surveillance to the injured employee, and to

destroy all materials collected after the applicable statute of limitations has expired. Finally, the bill would have allowed the identity of a witness or whistleblower who provides evidence in good faith to be withheld or limited to an in-camera review. **House Bill 10-1356**, as introduced, would have required Pinnacol Assurance to distribute surplus holdings in excess of 800 percent of risk based capital (RBC) to policyholders. RBC is the amount of required capital that an insurance company must maintain based on the inherent risks in the insurer's operations and is how the Commissioner of Insurance measures solvency.

Other workers' compensation related bills considered by the General Assembly included **Senate Bill 10-187**, which changes the Workers' Compensation Act of Colorado as follows:

- clarifies that Medicaid and other indigent health care programs are not considered wages for purposes of workers' compensation;
- allows an injured worker to recover costs other than attorneys' fees to pursue an order requiring an insurer to pay for a prescribed treatment plan;
- clarifies that for determining an injured worker's average weekly wage, the phrase "at the time of injury" refers to the date of the accident;
- eliminates permanent partial disability from the types of disabilities that require a social security offset;
- establishes standards for an injured worker to refuse an offer of modified employment and not be responsible for his or her termination of employment;
- adds the loss of a tooth and removes the loss of an eye to the list of scheduled injuries;
- requires the director of the Division of Workers' Compensation to adjust the caps on combined disability payments by the same percentage as the adjustment to the state average weekly wage beginning July 1, 2011; and
- prohibits the director or an administrative law judge from conditioning a lump sum payment on the injured workers' waiver of his or her right to pursue permanent total disability payments.

**Senate Bill 10-163** clarifies that Senate Bill 09-168, which amended various procedures in the Workers' Compensation Act, was intended to apply to all workers' compensation claims, regardless of when the claim was filed. The bill requires the director of the Division of Workers' Compensation to establish a life expectancy table based on mortality tables issued by the federal government or private industry on July 1 in even-numbered years. In addition, the bill requires that lump-sum settlements are required to be paid to a claimant within 15 days after an executed settlement order is received by the insurer. Finally, under the bill, documents required under the Workers' Compensation Act must be delivered in the same medium to all required recipients.

**Senate Bill 10-112** specifies that, effective January 1, 2011, for purposes of experience modifications, medical-only claims are to be calculated in the same manner as claims with indemnity payments. The bill also makes available to the public aggregate loss and payroll data by class code that a workers' compensation rating organization submits with rate filing and prohibits the use of the data for any commercial purpose.

**House Bill 10-1109** clarifies that the term "employee," for workers' compensation purposes, includes an inmate of a Department of Corrections facility or a city, county, or city and county jail who is working, performing services, or participating in a training, rehabilitation, or work release program that is certified by the federal Prison Industry Enhancement Certification Program (PIECP). Under the PIECP, the federal Bureau of Justice Assistance certifies that local or state prison industry programs meet all the necessary requirements to be exempt from federal restrictions on prisoner-made goods in interstate commerce. As a condition of participating in the PIECP, prison industry programs are required to carry workers' compensation insurance for any inmates working in such a program.

Public entities are authorized to select one workers' compensation insurance method in order to satisfy the requirements of the PIECP. The bill specifies that workers' compensation benefits for an injury or occupational disease arising from an inmate's participation in a PIECP-certified program will not be suspended for the period of time during which the inmate is incarcerated.

**Senate Bill 10-178** creates the Provider Review and Disclosure Act for workers' compensation insurers and health care providers. The bill specifies minimum standards for insurer performance programs that measure a provider's care. Insurers are required to file detailed descriptions of performance programs with the director of the Division of Workers' Compensation in the Department of Labor and Employment at least 30 days before implementation. Insurers must give written notice to a provider at least 45 days before disclosing the result of a performance program. If a provider appeals a result, an insurer is required to disclose the data and the process used to arrive at the provider's individual result. The provider has an opportunity to submit or to have considered corrected data or other relevant information. A violation of the bill's provisions is considered an unfair or deceptive act or practice and may be enforced in an administrative hearing or in a civil action against an insurer.

Finally, the Workers' Compensation Classification Appeals Board underwent a sunset review in 2009. **House Bill 10-1247** continues the board until July 1, 2021, as recommended by the review.

## **Health Insurance**

The General Assembly considered a variety of health insurance legislation during the 2010 session. Major topics addressed include mandating coverage for reproductive services, orally administered medications, prohibiting insurance carriers from using gender as a factor in determining rates, standardizing health insurance claims and establishing an all-payer claims database.

**Health insurance mandates.** Several bills introduced during the 2010 legislative session mandated health insurance companies to provide coverage for specific medications and treatments. **House Bill 10-1202** requires a health benefit plan that provides coverage for cancer chemotherapy

treatment to cover orally administered anticancer medication at a cost not to exceed the coinsurance percentage or relative copayment amount as is applied to intravenously administered or injected anticancer medication. Under the act, oral medication is covered if it is approved by the federal Food and Drug Administration, determined to be medically necessary to kill or slow the growth of cancerous cells, and not prescribed primarily for the convenience of the patient or physician.

**House Bill 1355** prohibits a health benefit plan that provides prescription drug coverage to exclude coverage for any cancer treatment drug on the basis that the drug has not been approved for the specific type of cancer being treated.

**House Bill 10-1021** requires individual health insurance policies to provide coverage for pregnancy and delivery and group and individual health insurance policies to provide coverage for contraception in the same manner as any other sickness, disease, or condition that is otherwise covered by that policy. Individual health insurance policies may exclude coverage for pregnancy and delivery on the grounds that pregnancy was a preexisting condition, however, the policy may not exclude coverage for subsequent pregnancies.

Last year, the legislature passed House Bill 09-1204 which requires preventative health care services to be covered by health insurance plans in accordance with recommendations made by the U.S. Preventative Services Task Force (USPSTF). The USPSTF recently recommended against routine breast cancer screening with mammography in women aged 40 to 49, and recommended biennial breast cancer screening with mammography for women between the ages of 50 and 75. **House Bill 10-1252** requires that insurance companies cover annual breast cancer screening with mammography for all individuals possessing at least one risk factor, including, but not limited to, having a family history of breast cancer, being 40 years of age or older, or having a genetic predisposition to breast cancer. The bill is effective January 1, 2011, and applies to policies and contracts entered into or renewed on or after that date

**House Bill 10-1154**, which was postponed indefinitely, would have repealed the Commission on Mandated Health Insurance Benefits and transferred its functions to the Director of Research of the Legislative Council. Under the bill, when a legislative measure containing a mandated health insurance benefit was proposed, the director was required to analyze the social and financial impact of the proposed mandate and include this information with the fiscal note. The Commissioner of Insurance would have charged insurance carriers fees to cover the costs of the analysis. The director could also accept and expend federal funds, gifts, grants, and donations to cover the cost of the analysis. Lastly, the bill included a one-year moratorium on the enactment of any new mandated health insurance benefits.

*Access to health insurance.* Several bills were introduced during the session which addressed increasing access to health insurance. **House Bill 10-1163** would have authorized the Commissioner of Insurance to enter into multi-state agreements with other states so that health insurers doing business in other states could offer, sell, or issue individual health plans in Colorado. These plans would have been regulated by the state issuing the plans. Prior to entering into a multi-state agreement, the commissioner was required to ensure that an insurer was financially viable; was able to provide adequate and appropriate access to health care providers and services; and had an adequate complaint and appeals process for Colorado consumers. The bill specified that a multi-state agreement must specify that the home state for the plan had sole jurisdiction and

responsibility to enforce the home state's laws in both the primary state and Colorado. The bill was postponed indefinitely.

**House Bill 10-1266** would have allowed certain local governments, small businesses, and nonprofit organizations to offer their employees participation in state medical and dental plans beginning January 1, 2011. By electing to extend state group benefits to its employees, an employer was required to exclusively offer state plans and participate in them for at least three years. The state personnel director would have been authorized to set minimum employer contributions towards its employees' premiums and charge an administrative fee to cover the state's costs. In the event that claims by employees of local governments, small businesses, or nonprofit organizations created a year-end deficit in group benefit plans, the state would have been authorized to collect an additional amount from employers proportional to their participation rate. The bill was also postponed indefinitely.

**House Bill 10-1103** would have allowed families of children with certain catastrophic medical conditions to apply for financial assistance. The financial assistance could be used for medical treatments, hospital care, prescription drugs, nursing care, and respite care. Financial assistance could not be used for items such as emergency respite care, medically necessary supplies, formula, diapers, durable medical equipment, home modifications, and adaptations to transportation. The bill, which was postponed indefinitely, would have assessed a \$1.00 fee on health and dental policies for each covered person in the state.

***Standardizing health insurance.*** Several bills passed during the 2010 legislative session that aimed at clarifying health insurance laws, simplifying language in health insurance policies, and promoting administrative efficiency. **House Bill 10-1166** requires that insurance policies and plans issued or renewed on or after January 1, 2012, be written at or below a 10th-grade reading level. The act specifies that the text of policies longer than 3,000 words or 3 pages must be in 10-point or larger type and must contain an index or table of contents.

**House Bill 10-1004** requires the Commissioner of Insurance to convene a group of stakeholders to develop standard formats for health insurance policy forms and explanation of benefit forms provided by health care carriers to consumers. The Insurance Commissioner is required to adopt rules after receiving input from the group of stakeholders. The act requires insurance carriers to implement the standardized formats for health benefit policies issued after January 1, 2012.

**House Bill 10-1242** requires the Commissioner of Insurance to implement an initial uniform application form for individual health benefit plans to be used on or after January 1, 2012. Upon receipt of an initial application form, an insurer can decide to issue coverage, request additional information, or deny coverage. If the insurer denies coverage based on the initial application form, the denial of coverage can be used for purposes of eligibility for coverage through CoverColorado.

Two bills passed during the 2010 legislative session aimed at increasing administrative efficiencies for processing health insurance claims. **House Bill 10-1332** creates the Medical Clean Claims Transparency and Uniformity Act. If sufficient funding is received through gifts, grants, and donations, the executive director of the Department of Health Care Policy and Financing is required to organize a task force of industry and government representatives to develop a standardized set of

payment rules and claim edits to be used by payers and health care providers in Colorado. The act outlines a specific timeline for the task force to establish a base set of standardized payment rules and claims edits. As part of the task force's recommendations, it is to address implementation, updating, and dissemination of the standardized set of payment rules and claim edits, including identifying who is responsible for establishing a central repository for the rules and edits.

**House Bill 10-1330** requires the Department of Health Care Policy and Financing to create a 25-member advisory committee to make recommendations for creating a Colorado all-payer health claims database. The advisory committee must create a database that is user-friendly, available to the public, and meet certain criteria for transparency and data quality. The act details the membership of the committee, specifically requiring the participation of various stakeholders in the health care field. The database is to be a repository of information concerning types of health care claims processed, transactions between health care providers and consumers, and the length of time spent processing such claims.

**Consumer protections.** Three bills passed during the 2010 legislative session that increased consumer protections for consumers of health insurance. **House Bill 10-1008** prohibits health insurance carriers from using gender as a factor in determining the rate for an individual health insurance policy. Under the bill, a premium rate based on gender is considered unfairly discriminatory. The bill takes effect January 1, 2011.

**Senate Bill 10-076** adds certain prohibitions to the unfair compensation practices concerning benefits claims. The act prohibits claims adjusters from receiving compensation or bonuses based on the number of policies cancelled, the number of times coverage is denied, the use of a quota limiting or restricting the number or volume of claims, and the use of an arbitrary quota or cap limiting or restricting the amount of claims payments without due consideration of the merits of the claim.

Under current law, out-of-network health care providers are prohibited from "balance billing" patients for in-network services through July 1, 2010. Balance billing occurs when a provider bills a patient for the difference between the out-of-network charge and the amount reimbursed by the insurance company for in-network services. **Senate Bill 10-183** continues this prohibition indefinitely and removes obsolete language concerning reporting by the Division of Insurance within the Department of Regulatory Agencies.

**Incentives for healthy living.** Last year, House Bill 09-1012 allowed health insurance carriers that provide individual and small group health insurance plans to offer incentives or rewards for participation in wellness and preventative programs. Wellness and preventative programs were defined to include:

- health screenings;
- mental health and substance abuse screenings;
- education and training about dietary habits;
- stress management;
- disease management;
- tobacco cessation programs; and
- health club memberships.

The act also stated that a participant was not required to achieve certain outcomes in order to receive the incentive. **House Bill 10-1160** repeals the restriction on incentives based on outcomes and allows carriers to base the incentives or rewards on satisfaction of a standard related to a health risk factor if the incentive or reward is consistent with the nondiscrimination requirements of the federal Health Insurance Portability and Accountability Act (HIPAA). Health risk factors under Health Insurance Portability and Accountability Act (HIPAA) include health behaviors such as smoking, diet, alcohol consumption, exercise, and exposure to UV radiation. The act requires health insurance carriers to submit proposed incentives or rewards programs to an accredited nonprofit organization that certifies wellness and incentive programs. The nonprofit is required to determine if the proposed incentive plan meets statutory requirements.