

INSURANCE

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HB 13-1309 (*Postponed Indefinitely*)
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for Breast Imaging

HB 13-1315 (*Enacted*)
Higher Education Undergrad Student
Health Insurance Requirement

The General Assembly heard a number of bills regarding insurance during the 2013 session, including bills related to regulatory changes; workers' compensation; homeowner's insurance; unemployment insurance; insurance, benefits, and protections; and health insurance.

Regulatory Changes

Four bills concerning regulatory changes to the insurance industry, overseen by the Department of Regulatory Agencies (DORA), were introduced during the 2013 session. Three concerned oversight of insurance practices, and one concerned the language used in insurance information.

Oversight of insurance practices. Three bills were introduced during the 2013 regarding oversight of the insurance industry. Two bills were enacted, one that increases regulation over public adjusters, and one that made a change to the way insurance companies may report suspected arson. Another bill, regarding changes to oversight authority of insurance intermediaries, was postponed indefinitely.

Public adjusters negotiate with insurance companies on behalf of policyholders to settle claims for loss or damage usually on a contingency basis. In Colorado, there are 256 licensed public adjusters that are currently regulated to a limited extent. **House Bill 13-1062**, enacted, increases the regulatory authority of the Commissioner of Insurance over public adjusters by adding them to the definition of insurance producers, which makes them subject to license suspension or revocation, as well as ethical standards, continuing education, and financial responsibility requirements. Catastrophic disaster is defined in the bill and a limit on compensation of 10 percent of any insurance settlement or proceeds for public adjusters are specified in the event of a catastrophic disaster.

House Bill 13-1262, enacted, expands the Fraudulent Claims and Arson Reporting Act. It allows an insurer who has reason to believe that a fire loss may have been caused by arson the right to report that information to a secondary agency. An insurer may also report any claim it believes to be fraudulent to the secondary agency. The bill defines secondary agency as any for-profit or nonprofit organization funded directly or indirectly by insurers that collects and disseminates information on insurance fraud. Secondary agencies receive designation by the Commissioner of Insurance; maintain the confidentiality of the information collected; and receive immunity from civil liability when disseminating the information.

Intermediaries are people authorized by health care providers or insurance carriers to negotiate and execute provider contracts with insurance carriers. **Senate Bill 13-124**, postponed indefinitely, would have given the Commissioner of Insurance in DORA the authority to investigate complaints filed against intermediaries by providers and consumers for specific actions including failure to promptly pay a claim, altering provider charges, and altering a provider contract without written consent. Willful violation of the provisions of this bill would have been defined as unfair methods of competition. The bill would not have authorized the Commissioner to take corrective action against intermediaries.

Language use in insurance information. One bill was enacted during the General Assembly regarding the use of foreign languages in insurance documents.

House Bill 13-1233, enacted, authorizes, but does not require, the use of a language other than English in insurance policies, insurance-related documents, insurance advertising, and insurance transactions. Non-English language insurance policies must be translated from an English language policy, and the English language version is controlling in the event of a dispute.

Copies of translated policy documents are maintained by an insurer and must be furnished to state insurance regulators upon request.

Workers' Compensation

Three bills were enacted in the 2013 legislative session that made changes to the state's workers' compensation policies related to: delivery subcontractors, timeliness of an independent medical examiner's report review, and workers' compensation insurance deductibles.

Senate Bill 13-147, enacted, clarifies the presumption that a buyer of goods is not liable for a workers' compensation claim if a leased or subcontracted employee who is delivering goods to the buyer is injured while not on the buyer's premises. This presumption may be overcome by a showing that the leased or subcontracted employee was performing a job function that would normally be performed by an employee of the buyer of the goods being delivered. This bill does not create a presumption of a statutory employer-employee relationship when an injury occurs on the buyer's premises.

Senate Bill 13-249, enacted, requires the Division of Workers' Compensation (division), Colorado Department of Labor and Employment (CDLE), to review an independent medical examiner's (IME) report within five days of its receipt and either notify all parties that the report has been received or notify the IME of any deficiencies in the IME report with copies to all parties. The IME has 20 days to remedy the deficiencies and resubmit the IME report. If the IME does not meet the 20-day deadline, the division will issue a notice that it has received the IME report and the insurer or self-insured employer must either file an admission of liability or request a hearing to contest the findings in the IME report within 20 days. The insurer or self-insured employer's response time is reduced from 30 days under current law.

Under current law, workers' compensation policies are limited to a maximum \$5,000 deductible. An employer with a \$5,000 deductible is responsible for all claims less than \$5,000, as well as the first \$5,000 of claims above \$5,000. **House Bill 13-1025**, enacted, increases the maximum amount of deductible to the amount of the workers' compensation insurance rate split point approved by the Commissioner of Insurance, Department of Regulatory Agencies. The split point is the amount of each loss that an insurer may apply as the primary loss in each workers' compensation claim when calculating an employer's experience rating. The experience rating is used to determine the amount the employer pays for workers' compensation coverage. The bill clarifies that it is a violation of the Workers' Compensation Act for an employer or insurer to require an employee to pay for, or use any other type of insurance to pay for, treatment of a workplace injury.

Homeowner's Insurance

Two bills were introduced during the 2013 session. One bill concerning reforms to homeowner's insurance was enacted. A bill that required cancellation of insurance to be sent certified mail was deemed lost.

House Bill 13-1225, enacted, creates the "Homeowner's Insurance Reform Act of 2013" and makes several changes to the regulation of homeowner's insurance, primarily for single-family homes used as a primary residence by the owner. It requires insurers to provide to homeowner's insurance policyholders a specific disclosure, at least once a year, regarding the homeowner's policy limits, replacement value, and the importance of preparing an inventory of the contents of the home and outbuildings. In addition, the bill outlines changes to the language, documentation

and coverage requirements of homeowner's insurance. Finally, on or after January 1, 2014, the bill makes void any provision in a homeowner's policy that requires the policyholder to sue the insurer, in the case of any dispute, within a shorter period of time than allowed for by the applicable statute of limitations.

Under current law, an insurer is required to mail cancellation or non-renewal notices, together with the reasons for the cancellation or non-renewal, to homeowner's insurance policyholders by first-class mail. **Senate Bill 13-211**, deemed lost, would have required that these notices be sent by certified mail.

Unemployment Insurance

The General Assembly passed three bills that made changes to state unemployment insurance (UI) law, specifically related to retirement plans withdrawals, optional confidentiality waivers for job seekers, and conformity with federal UI law.

Under current law, if a UI claimant withdraws any moneys from an employer-sponsored retirement plan, the full balance of the claimant's account is used to determine the length of time the claimant must wait to become eligible to receive UI benefits. **House Bill 13-1054**, enacted, requires that the CDLE use only the amount withdrawn and not reinvested to determine the number of weeks that the claimant's benefits are postponed.

House Bill 13-1123, enacted, allows the CDLE to offer anyone seeking employment, including veterans, the opportunity to waive confidentiality for contact information. The confidentiality is waived so that the department may make the information available to bona fide employers seeking employees. Confidentiality is waived for name, address, telephone number, and e-mail address.

House Bill 13-1124, enacted, conforms Colorado UI law with the federal "Trade Adjustment Assistance Extension Act of 2011." When an employer repeatedly fails to provide timely information that results in an overpayment of benefits to an individual, the employer's account will be charged for the overpayment. The fraudulent overpayment penalty is increased from 50 percent to 65 percent of the overpayment charged to the person who receives the overpayment. The revenue from the penalty is split with 23 percent going to the Unemployment Compensation Fund and 77 percent to the CDLE's Unemployment Revenue Fund.

Insurance, Benefits, and Protections

Three bills were introduced and enacted by the General Assembly concerning changes to the provisions of life and health insurance, savings protection, and benefit plans, specifically related to insurance consumer protection, contracted savings protection, and benefit plan requirements.

Senate Bill 13-032, enacted, amends the statutes that govern the Life and Health Insurance Protection Association (LHIPA) to more closely match guaranty associations in other states. Among the provisions, the bill:

- allows LHIPA to cover an impaired insurer to keep it operating;
- requires the Commissioner of Insurance to notify LHIPA of an impaired insurer;
- clarifies that long-term care is a health coverage with \$300,000 coverage protection;

- raises the annual industry assessment maximum from 1 percent to 2 percent of a 3-year average of premiums;
- allows the LHIGA board to set administrative assessments;
- eliminates the exclusion for non-U.S. citizens; and
- excludes coverage for Medicare Parts C and D.

The regulation of insurance is delegated to the states by the federal government. The bill follows the guidelines of the National Association of Insurance Commissioners model laws in order to develop consistency with other states.

Senate Bill 13-125, enacted, modifies the regulation of preneed funeral contracts by the Commissioner of Insurance in DORA. It makes the following changes:

- eliminates the requirement that preneed contract sellers be audited every five years;
- directs the commissioner to make every effort to utilize division employees to conduct audits;
- requires a preneed contract business to obtain commissioner approval prior to selling a preneed contract business and directs the commissioner to monitor funds in trust for inactive preneed sellers and cancel the license when the funds in trust are exhausted or each preneed contract is fulfilled; and
- exempts from regulation a person providing a developed final resting place within a designated cemetery, or a person providing undeveloped final resting places that meet certain conditions.

Upon the death of a contract beneficiary, a preneed contract provides for a final resting place, merchandise, or services associated with the disposition of the beneficiary's body.

Senate Bill 13-240, enacted, modifies voting requirements for the Fire and Police Pension Association to modify benefits, age and service requirements, and member contribution rates under the statewide defined benefit plan. Under current law, 65 percent of all active plan members and 50 percent of all employers with active plan members must approve of such modifications. The bill requires approval based on the percentage of eligible voting members and employers who actually vote in the election proposing a modification.

Health Insurance

During the 2013 legislative session, the General Assembly considered several bills related to health insurance coverage and regulation. Many of the bills were related to federal health care reform and can be found under the Summary of Major Health Legislation. The following are some of the bills the General Assembly deliberated on that concern private health insurance, but that are not related to federal health care reform.

Two bills concerning the All-Payer Health Claims Database, which was created in 2010 to provide transparent public reporting of health care information, were enacted. The first bill, **Senate Bill 13-149**, reestablishes the All-Payer Health Claims Database Advisory Committee to support the mission of the All-Payer Health Claims Database. The database administrator must submit annual reports to the legislature. Additionally, the Department of Health Care Policy and Financing's executive director will require an evaluation of the database every five years beginning in 2018, which must contain metrics that document and demonstrate the achievements or challenges of the program goals. The second bill, **House Bill 13-1015**, repeals the prohibition on disclosure of certain mental health information by small group carriers, thereby allowing the information to be reported to the All-Payer Health Claims Database.

Prior to the enactment of **House Bill 13-1223**, all health insurance carriers doing business in Colorado were required to submit detailed cost information to the Commissioner of Insurance for inclusion in the annual Health Cost Report. The bill allows the commissioner to specify, by rule, a minimum threshold which carriers must meet before they are required to submit cost information. The commissioner must ensure that at least 92 percent of the market reports cost information.

Prior authorization is an extra step that some insurance carriers require before deciding to approve coverage of a patient's medicine. **Senate Bill 13-277** requires the Commissioner of Insurance to develop by July 31, 2014, by rule, a uniform prior authorization process for insurance carriers to submit and receive requests for prior coverage approval of a drug benefit. The bill outlines the procedure for the development of the uniform prior authorization process. Under the prior authorization process developed by the commissioner, insurance carriers and pharmacy benefit management firms (carriers) must meet certain requirements related to prior authorization. Carriers are required to begin using the uniform prior authorization process on January 1, 2015, and timelines for the prior authorization process are specified in statute.

Excess loss or stop-loss health insurance policies used in association with a self-insured health plan are designed to help protect the employer from extremely high or catastrophic claims. With a stop-loss health insurance policy, an employer pays all claims up to a predetermined amount, also known as the attachment point, and then the stop-loss health insurance policy pays for claims above that amount. A stop-loss health insurance policy can have an annual attachment point per individual or an annual aggregate attachment point for the small employer group. **House Bill 13-1290** changes the law that regulates excess loss or stop-loss health insurance policies used with health benefit plans for self-insured employers with no more than 50 employees. It requires insurers that sell excess loss or stop-loss policies to report specific policy information to the Commissioner of Insurance annually from 2013 through 2018. Additionally, the bill establishes criteria for the issuance of stop-loss health insurance policies and requires each insurer to certify with the commissioner that the insurer is in compliance with the regulatory requirements of this bill.

House Bill 13-1309, which was postponed indefinitely by the Senate Health and Human Services Committee, concerned health insurance coverage for preventative breast imaging. A mammogram is one type of breast imaging used for screening and diagnostic purposes and is a mandatory coverage provision for insurance policies regulated by state law. For individuals with at least one risk factor for breast cancer, the bill would have expanded insurance coverage to include all types of breast imaging. Additionally, insurance coverage for breast imaging would not have been subject to policy deductibles, co-payments, or coinsurance.

Under current law, the governing board of an institution of higher education may not require that an undergraduate student purchase health care insurance or services. Institutions that had such requirements prior to 1994 are exempt from this prohibition. **House Bill 13-1315** eliminates the prohibition, thus authorizing any governing board to require student health care insurance.