Title 10. Insurance (Refs & Annos)
Regulation of Insurance Companies
Article 3. Regulation of Insurance Companies (Refs & Annos)
Part 11. Unfair Competition--Deceptive Practices (Refs & Annos)

C.R.S.A. § 10-3-1101

§ 10-3-1101. Legislative declaration

Currentness

The purpose of this part 11 is to regulate trade practices in the business of insurance by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices, and by prohibiting the trade practices so defined or determined. No rules or regulations shall be promulgated to adversely affect free and open competition in the sale of insurance.

Notes of Decisions (12)

C. R. S. A. § 10-3-1101, CO ST § 10-3-1101
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

End of Document

Title 10. Insurance (Refs & Annos)
Regulation of Insurance Companies
Article 3. Regulation of Insurance Companies (Refs & Annos)
Part 11. Unfair Competition--Deceptive Practices (Refs & Annos)

C.R.S.A. § 10-3-1102

§ 10-3-1102. Definitions

Currentness

As used in this part 11, unless the context otherwise requires:

(1) “Commissioner” means the commissioner of insurance.

(2) “Insurance policy” or “insurance contract” means any contract of insurance, indemnity, medical or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any person.

(2.5) Repealed by Laws 1981, H.B.1256, § 5, eff. June 4, 1981.

(3) “Person” means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, nonadmitted insurer, fraternal benefit society, and other legal entities engaged in the insurance business, including agents, limited insurance representatives, agencies, brokers, surplus line brokers, and adjusters. Such term shall also include medical service plans and hospital service plans regulated under parts 1 and 3 of article 16 of this title and health maintenance organizations regulated under parts 1 and 4 of article 16 of this title. Such plans and organizations shall be deemed to be engaged in the business of insurance for purposes of this part 11 only.

Credits
Amended by Laws 1978, H.B.1004, § 1, eff. July 1, 1978; Laws 1981, H.B.1256, § 5, eff. June 4, 1981; Laws 1984, H.B.1377, § 1, eff. July 1, 1984; Laws 1987, H.B.1291, § 1, eff. May 1, 1987; Laws 1992, S.B.92-104, § 4, eff. July 1, 1992; Laws 1995, H.B.95-1271, § 5, eff. May 16, 1995.

Notes of Decisions (1)

C. R. S. A. § 10-3-1102, CO ST § 10-3-1102
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

End of Document

Title 10. Insurance (Refs & Annos)
Regulation of Insurance Companies
Article 3. Regulation of Insurance Companies (Refs & Annos)
Part 11. Unfair Competition--Deceptive Practices (Refs & Annos)

C.R.S.A. § 10-3-1103

§ 10-3-1103. Unfair methods of competition--unfair or deceptive acts or practices--prohibited

Currentness

No person shall engage in this state in any trade practice which is defined in this part 11 as, or determined pursuant to section 10-3-1107 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

C. R. S. A. § 10-3-1103, CO ST § 10-3-1103
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

End of Document

Title 10. Insurance (Refs & Annos)
Regulation of Insurance Companies
Article 3. Regulation of Insurance Companies (Refs & Annos)
Part 11. Unfair Competition--Deceptive Practices (Refs & Annos)

C.R.S.A. § 10-3-1104

§ 10-3-1104. Unfair methods of competition--unfair or deceptive acts or practices

Effective: August 5, 2015
Currentness

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(a) Misrepresentations and false advertising of insurance policies: Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, circular, statement, sales presentation, omission, or comparison which:

(I) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy; or

(II) Misrepresents the dividends or share of the surplus to be received on any insurance policy; or

(III) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; or

(IV) Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; or

(V) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; or

(VI) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy; or

(VII) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(VIII) Misrepresents any insurance policy as being a security; or

(IX) Misrepresentation shall not be construed where a written comparison of policies is made factually disclosing relevant features and benefits for which the policy is issued and by which an informed decision can be made;

(b) False information and advertising generally:

(I) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his or her insurance business, which is untrue, deceptive, or misleading;

(II) Knowingly filing with the commissioner or other public official, or with any employee or agent of the division of insurance in the department of regulatory agencies, a written, false statement of material fact as to the financial condition of an insurer;

(III) Knowingly making any false entry of a material fact in any book, report, or other written statement of any insurer; knowingly omitting or failing to make a true entry of a material fact pertaining to the business of the insurer in any book, report, or other written statement of the insurer; or knowingly making any written, false material statement to the commissioner or any employee or agent of the division of insurance in the department of regulatory agencies;

(c) Defamation: Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical, or derogatory to the financial condition of any person, and which is calculated to injure such person;

(d) Boycott, coercion, and intimidation: Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(e) Stock operations and advisory board contracts: Issuing or delivering, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares, in any corporation, or securities, or any special or advisory board contracts, or other contracts of any kind promising returns and profits as an inducement to insurance;

(f)(I) Unfair discrimination: Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract;

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(III) Making or permitting to be made any classification solely on the basis of marital status or sex, unless such classification is for the purpose of insuring family units or is justified by actuarial statistics;

(IV) Making or permitting to be made any classification solely on the basis of blindness, partial blindness, or a specific physical disability unless such classification is based upon an unequal expectation of life or an expected risk of loss different than that of other individuals;

(V) Repealed by Laws 1980, S.B.114, § 2, eff. April 10, 1980.

(VI) Inquiring about or making an investigation concerning, directly or indirectly, an applicant's, an insured's, or a beneficiary's sexual orientation in:

(A) An application for coverage; or

(B) Any investigation conducted in connection with an application for coverage;

(VII) Using information about gender, marital status, medical history, occupation, residential living arrangements, beneficiaries, zip codes, or other territorial designations to determine sexual orientation;

(VIII) Using sexual orientation in the underwriting process or in the determination of insurability;

(IX) Making adverse underwriting decisions because an applicant or an insured has demonstrated concerns related to AIDS by seeking counseling from health care professionals;

(X) Making adverse underwriting decisions on the basis of the existence of nonspecific blood code information received from the medical information bureau, but this prohibition shall not bar investigation in response to the existence of such nonspecific blood code as long as the investigation is conducted in accordance with the provisions of section 10-3-1104.5;

(XI) Reducing benefits under a health insurance policy by the addition of an exclusionary rider, unless such rider only excludes conditions which have been documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition;

(XII) Denying health care coverage subject to article 16 of this title to any individual based solely on that individual's casual or nonprofessional participation in the following activities: Motorcycling; snowmobiling; off-highway vehicle riding; skiing; or snowboarding;

(XIII) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy of sickness and accident insurance, in the benefits payable under such policy, in the terms or conditions of the policy, or in any other manner;

(XIV) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling, or limiting the amount of insurance coverage on a property and casualty risk solely because of the geographic location of the risk, unless the action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience;

(XV) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, canceling, or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property;

(XVI) Terminating or modifying coverage or refusing to issue or renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired; except that this subparagraph (XVI) does not:

(A) Apply to accident and health insurance sold by a casualty insurer; or

(B) Modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract;

(XVII) Refusing to insure a person solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy, in which the person was the named insured. Nothing in this subparagraph (XVII) prevents an insurer from terminating an excess insurance policy based on the failure of the insured to maintain any required underlying insurance.

(g) Rebates: Except as otherwise expressly provided by law, knowingly permitting, or offering to make, or making any contract of insurance or agreement as to such contract, other than as plainly expressed in the insurance contract issued thereon, or paying, or allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance contract or annuity or in connection therewith any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(I) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; or

(II) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies; or

(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or

(IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information; or

(V) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; or

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; or

(VII) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; or

(VIII) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application; or

(IX) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured; or

(X) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made; or

(XI) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; or

(XII) Delaying the investigation or payment of claims by requiring an insured or claimant, or the physician of either of them, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; or

(XIII) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(XIV) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or

(XV) Raising as a defense or partial offset in the adjustment of a third-party claim the defense of comparative negligence as set forth in section 13-21-111, C.R.S., without conducting a reasonable investigation and developing substantial evidence in support thereof. At such time as the issue is raised under this subparagraph (XV), the insurer shall furnish to the commissioner a written statement setting forth reasons as to why a defense under the comparative negligence doctrine is valid.

(XVI) Excluding medical benefits under health care coverage subject to article 16 of this title to any covered individual based solely on that individual's casual or nonprofessional participation in the following activities: Motorcycling; snowmobiling; off-highway vehicle riding; skiing; or snowboarding; or

(XVII) Failing to adopt and implement reasonable standards for the prompt resolution of medical payment claims.

(i) Failure to maintain complaint handling procedures: Failing of any insurer to maintain a complete record of all the complaints which it has received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this paragraph (i), “complaint” shall mean any written communication primarily expressing a grievance.

(j) Misrepresentation in insurance applications: Making false or fraudulent statements or representations on or relative to any application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any person;

(k) Requiring, directly or indirectly, any insured or claimant to submit to any polygraph test concerning any application for or any claim under any policy of insurance;

(l) Violation of or noncompliance with any insurance law in part 6 of article 4 of this title;

(m) Failure to make promptly a full refund or credit of all unearned premiums to the person entitled thereto upon termination of insurance coverage;

(n) Requiring or attempting to require or otherwise induce a health care provider, as defined in section 13-64-403(12)(a), C.R.S., to utilize arbitration agreements with patients as a condition of providing medical malpractice insurance to such health care provider;

(o) Failure to comply with all the provisions of section 10-3-1104.5 regarding HIV testing;

(p) Violation of or noncompliance with any provision of part 13 of this article;

(q) Increasing the premiums unilaterally or decreasing the coverage benefits on renewal of a policy of insurance, increasing the premium on new policies, or failing to issue an insurance policy to barbers, cosmetologists, estheticians, nail technicians, barbershops, or beauty salons, as regulated in article 8 of title 12, C.R.S., regardless of the type of risk insured against, based solely on the decision of the general assembly to stop mandatory inspections of the places of business of such insureds;

(r) Repealed by Laws 2013, Ch. 338, § 4, eff. Mar. 31, 2015.

(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

(t) Certifying pursuant to section 10-4-419 or issuing, soliciting, or using a claims-made policy form, endorsement, or disclosure form that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(u) Certifying pursuant to section 10-4-633 or issuing, soliciting, or using an automobile policy form, endorsement, or notice form that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(v) Failure to comply with all provisions of section 10-16-108.5 concerning fair marketing of health benefit plans and section 10-16-105 concerning guaranteed issuance of individual and small employer health benefit plans;

(w) Failure to comply with the provisions of section 10-16-105.1 concerning the renewability of health benefit plans;

(x) Violation of the provisions of part 8 of article 1 of title 25, C.R.S., concerning patient records;

(y) Violating any provision of the “Consumer Protection Standards Act for the Operation of Managed Care Plans”, part 7 of article 16 of this title by those subject to said part 7;

(z) Willfully violating any provision of section 10-16-113.5;

(aa) Certifying pursuant to section 10-10-109(3) or 10-10-109(4), issuing, soliciting, or using a credit insurance policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider that does not comply with Colorado law. Such certification, issuance, solicitation, or use shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(bb) Certifying pursuant to section 10-15-105(1), issuing, soliciting, or using a preneed funeral contract form or a form of assignment that does not comply with Colorado law. Such certification, issuance, solicitation, or use shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(cc) Violation of the provisions of section 10-16-122(4) concerning an unauthorized transfer of a covered person or subscriber's prescription;

(dd) Failing to comply with the provisions of section 10-4-628(2)(a)(V) or 10-16-201(5);

(ee) Willfully or repeatedly violating section 10-11-108(1)(c) or (1) (d), including a willful or repeated violation through the creation or operation of an improper affiliated business arrangement;

(ff) Violation of the “Physician and Dentist Designation Disclosure Act”, article 38 of title 25, C.R.S.;

(gg) Violation of section 10-16-705(6.5) or (10.5);

(hh) Unfair compensation practices: Basing the compensation of claims employees or contracted claims personnel, including compensation in the form of performance bonuses or incentives, on any of the following:

(I) The number of policies canceled;

(II) The number of times coverage is denied;

(III) The use of a quota limiting or restricting the number or volume of claims; or

(IV) The use of an arbitrary quota or cap limiting or restricting the amount of claims payments without due consideration of the merits of the claim;

(ii) Violation of section 8-43-401.5, C.R.S.;

(jj) Violation of part 6 of article 43 of title 8, C.R.S.;

(kk) Violation of section 10-7-703 of the “Insurable Interest Act”, part 7 of article 7 of this title;

(*ll*) Engaging in stranger originated life insurance;

(mm) Paying a fee or rebate or giving or promising anything of value to a jailer, peace officer, clerk, deputy clerk, an employee of a court, district attorney or district attorney's employees, or a person who has power to arrest or to hold a person in custody as a result of writing a bail bond;

(nn) Unless the indemnitor consents in writing otherwise, failure to post a bail bond within twenty-four hours after receipt of full payment or a signed contract for payment, and if the bail bond is not posted within twenty-four hours after receipt of full payment or a signed contract for payment, failure to refund all moneys received, release all liens, and return all collateral within seven days after receipt of good funds;

(oo) Failure to report, preserve without use, retain separately, or return after payment in full, collateral taken as security on any bail bond to the principal, indemnitor, or depositor of the collateral;

(pp) Soliciting bail bond business in or about any place where prisoners are confined, arraigned, or in custody;

(qq) Failure to pay a final, nonappealable judgment award for failure to return or repay collateral received to secure a bond; or

(rr) Certifying pursuant to section 8-44-102, C.R.S., or issuing, soliciting, or using a workers' compensation form, endorsement, rider, letter, or notice that does not comply with statutory mandates. The solicitation or certification is subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(2) Nothing in paragraph (f) or (g) of subsection (1) of this section shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, if any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

(c) Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(d) Requests by a person that an applicant or insured take an HIV related test when such request has been prompted by either the health history or current condition of the applicant or insured or by threshold coverage amounts which are applied to all persons within the risk class, as long as such test is conducted in accordance with the provisions of section 10-3-1104.5.

(3) Repealed by Laws 1981, H.B.1256, § 5, eff. June 4, 1981.

(4) The following is defined as an unfair practice in the business of insurance: For an insurer to deny, refuse to issue, refuse to renew, refuse to reissue, cancel, or otherwise terminate a motor vehicle insurance policy, to restrict motor vehicle insurance coverage on any person, or to add any surcharge or rating factor to a premium of a motor vehicle insurance policy solely because of:

(a) A conviction under section 12-47-901(1)(b), C.R.S., or section 18-13-122(3), C.R.S., or any counterpart municipal charter or ordinance offense or because of any driver's license revocation resulting from such conviction. This paragraph (a) includes, but is not limited to, a driver's license revocation imposed under section 42-2-125(1)(m), C.R.S.

(b) The licensee's inability to operate a motor vehicle due to physical incompetence if the licensee obtains an affidavit from a rehabilitation provider or licensed physician acceptable to the department of revenue.

(5) It shall not be an unfair practice in the business of insurance for an insurer to pay an assignee if the insurer believes in good faith that the claim is subject to a written assignment from the insured. The insurer shall remain responsible to the insured for

such amounts pursuant to the applicable policy terms in the event the person paid did not hold a written assignment and did not provide services or goods to the insured at the insured's request.

Credits

Amended by Laws 1975, H.B.1446, § 1, eff. July 1, 1975; Laws 1978, H.B.1004, § 2, eff. March 24, 1978; Laws 1978, S.B.88, § 1, eff. March 21, 1978; Laws 1979, H.B.1510, § 5, eff. June 22, 1979; Laws 1979, S.B.360, § 1, eff. July 1, 1979; Laws 1980, S.B.114, § 2, eff. April 10, 1980; Laws 1981, H.B.1256, § 5, eff. June 4, 1981; Laws 1988, H.B.1107, § 3, eff. July 1, 1988; Laws 1988, S.B.143, § 4, eff. July 1, 1988; Laws 1989, H.B.1155, § 2, eff. July 1, 1990; Laws 1989, S.B.167, §§ 2, 3, 4, eff. April 12, 1990; Laws 1990, H.B.90-1009, § 29, eff. July 1, 1990; Laws 1992, S.B.92-42, § 1, eff. April 16, 1992; Laws 1992, S.B.92-90, § 52, eff. May 20, 1992; Laws 1992, S.B.92-114, § 3, eff. June 2, 1992; Laws 1992, S.B.92-179, § 3, eff. May 29, 1992; Laws 1993, H.B.93-1270, § 6, eff. Jan. 1, 1995; Laws 1994, H.B.94-1210, § 13, eff. July 1, 1994; Laws 1996, H.B.96-1232, § 2, eff. July 1, 1996; Laws 1997, H.B.97-1122, § 4, eff. July 1, 1997; Laws 1997, H.B.97-1131, §§ 1, 2, eff. Oct. 1, 1997; Laws 1997, H.B.97-1157, § 4, eff. April 19, 1997; Laws 1997, H.B.97-1316, § 6, eff. Aug. 6, 1997; Laws 1998, Ch. 226, § 8, eff. Aug. 5, 1998; Laws 1999, Ch. 109, § 2, eff. Aug. 4, 1999; Laws 1999, Ch. 267, § 3, eff. June 1, 2000; Laws 2000, Ch. 135, § 2, eff. Aug. 2, 2000; Laws 2000, Ch. 342, § 7, eff. June 1, 2000; Laws 2001, Ch. 281, § 36, eff. July 1, 2001; Laws 2001, Ch. 310, § 3, eff. Jan. 1, 2002; Laws 2002, Ch. 27, § 1, eff. Jan. 1, 2003; Laws 2003, Ch. 234, § 4, eff. July 1, 2003; Laws 2004, Ch. 255, § 21, eff. May 21, 2004; Laws 2004, Ch. 295, § 2, eff. July 1, 2004; Laws 2005, Ch. 58, § 3, eff. April 14, 2005; Laws 2006, Ch. 84, § 4, eff. July 1, 2006; Laws 2008, Ch. 403, § 2, eff. Sept. 1, 2008; Laws 2009, Ch. 197, § 2, eff. Aug. 5, 2009; Laws 2010, Ch. 197, §§ 6, 7, eff. July 1, 2010; Laws 2010, Ch. 228, § 1, eff. May 17, 2010; Laws 2010, Ch. 290, § 2, eff. July 1, 2010; Laws 2010, Ch. 302, § 5, eff. May 27, 2010; Laws 2011, Ch. 227, § 2, eff. May 27, 2011; Laws 2012, Ch. 280, § 37, eff. July 1, 2012; Laws 2013, Ch. 217, § 42, eff. May 13, 2013; Laws 2013, Ch. 338, § 4, eff. May 28, 2013; Laws 2014, Ch. 78, § 2, eff. Aug. 6, 2014; Laws 2014, Ch. 387, § 4, eff. June 6, 2014; Laws 2015, Ch. 95, § 8, eff. Aug. 5, 2015; Laws 2015, Ch. 122, § 20, eff. May 1, 2015.

Notes of Decisions (104)

C. R. S. A. § 10-3-1104, CO ST § 10-3-1104

Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

End of Document

 KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

Title 10. Insurance (Refs & Annos)
Regulation of Insurance Companies
Article 3. Regulation of Insurance Companies (Refs & Annos)
Part 11. Unfair Competition--Deceptive Practices (Refs & Annos)

C.R.S.A. § 10-3-1104.5

§ 10-3-1104.5. HIV testing--legislative declaration--definitions--requirements for testing--limitations on disclosure of test results

Currentness

(1) The general assembly declares that a balance must be maintained between the need for information by those conducting the business of insurance and the public's need for fairness in practices for testing for the human immunodeficiency virus, including the need to minimize intrusion into an individual's privacy and the need to limit disclosure of the results of such testing.

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

(a) “AIDS” means acquired immunodeficiency syndrome.

(b) “Applicant” means the individual proposed for coverage.

(c) “HIV” means human immunodeficiency virus.

(d) “HIV infection” means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS.

(e) “HIV related test” means any laboratory test or series of tests for any virus, antibody, antigen, or etiologic agent whatsoever thought to cause or to indicate the presence of AIDS.

(f) “Person” means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the insurance business, except insurance agents and brokers. Such term shall also include medical service plans and hospital service plans regulated under parts 1 and 3 of article 16 of this title and health maintenance organizations regulated under parts 1 and 4 of article 16 of this title. Such plans and health maintenance organizations shall be deemed to be engaged in the business of insurance for purposes of this section.

(3) No person shall request or require that an applicant submit to an HIV related test unless that person:

(a) Obtains the applicant's prior written informed consent; and

(b) Reveals, in the written consent form, and explains the use of the HIV related test result to the applicant and entities to whom test results may be disclosed pursuant to paragraphs (a) and (b) of subsection (4) of this section; and

(c) Provides the applicant with:

(I) Printed material prior to testing which contains factual information describing AIDS; its causes, symptoms, and transmission; and the tests used to detect HIV infection and what a person should do if the result of the HIV related test is positive; or

(II) Information on how to obtain relevant counseling from a qualified practitioner having extensive training and experience in addressing the fears, questions, and concerns of persons tested for HIV infection; and

(d) Administers the HIV related test based upon the following test protocol, as a minimum:

(I) Two positive ELISA tests and a western blot test with bands present at p24, p31, and either gp41 or gp160; or

(II) An equally reliable screening or confirmatory test protocol designated by the commissioner, with the approval of the department of public health and environment; and

(e) Discloses the results of testing in the manner prescribed by subsection (4) of this section.

(4)(a) On the basis of the applicant's written informed consent as specified in subsection (3) of this section, a person may disclose an individual applicant's HIV related test results to its reinsurers or to those contractually retained medical personnel, laboratories, and insurance affiliates, excluding agents and brokers, which are involved in underwriting decisions regarding the individual's application if disclosure is necessary to make underwriting decisions regarding such application.

(b) Other than the disclosures permitted by paragraph (a) of this subsection (4), no person shall disclose HIV related test results which identify the individual applicant with the test results obtained to anyone without first obtaining separate written informed consent for such disclosure from the applicant; except that, if the result of the HIV related test of an applicant is positive or indeterminate, such person may report the test finding to the medical information bureau but only if a nonspecific blood test result code is used which does not indicate that the applicant was tested for HIV infection.

(c) Nothing in this subsection (4) shall be construed to prohibit reporting as required by the provisions of sections 25-4-1402, 25-4-1403, and 25-4-1405(8), C.R.S.

(5) A person shall notify the applicant in writing of an adverse underwriting decision based upon the results of such applicant's blood test but shall not disclose the specific results of such blood test to such applicant. The person shall also inform the applicant that the results of the blood test will be sent to the physician designated by the applicant at the time of application and that such

physician should be contacted for information regarding the HIV related test. If a physician was not designated at the time of application, the person shall request that the applicant name a physician to whom a copy of the blood test can be sent.

(6) Notwithstanding any other provisions to the contrary, any person who fails to comply with all the provisions of this section regarding the disclosure of HIV related test results is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than five hundred dollars nor more than five thousand dollars, or by imprisonment in the county jail for not less than six months nor more than twenty-four months, or both such fine and imprisonment.

Credits

Amended by Laws 1989, S.B.167, § 1, eff. April 12, 1989; Laws 1992, S.B.92-104, § 5, eff. July 1, 1992; Laws 1994, H.B.94-1029, § 318, eff. July 1, 1994.

C. R. S. A. § 10-3-1104.5, CO ST § 10-3-1104.5

Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1104.6

§ 10-3-1104.6. Genetic information--limitations on disclosure of information--liability--definitions--legislative declaration

Effective: August 11, 2010
Currentness

(1) The general assembly hereby finds and determines that recent advances in genetic science have led to improvements in the diagnosis, treatment, and understanding of a significant number of human diseases. The general assembly further declares that:

(a) Genetic information is the unique property of the individual to whom the information pertains;

(b) Any information concerning an individual obtained through the use of genetic services may be subject to abuses if disclosed to unauthorized third parties without the willing consent of the individual to whom the information pertains;

(c) To protect individual privacy and to preserve individual autonomy with regard to the individual's genetic information, it is appropriate to limit the use and availability of genetic information;

(d) The intent of this section is to prevent genetic information from being used to deny access to health care insurance or medicare supplement insurance coverage.

(2) For the purposes of this section:

(a) “Entity” means any sickness and accident insurance company, health maintenance organization, nonprofit hospital, medical-surgical and health service corporation, or other entity that provides health care insurance or medicare supplement insurance coverage and is subject to the jurisdiction of the commissioner of insurance.

(b) “Family member” means an individual who is related to another individual by blood, adoption, or marriage within the first, second, third, or fourth degree.

(c)(I) “Genetic information” means information about an individual's genetic test, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members of the individual. “Genetic information” includes any request for, or receipt of, genetic services with respect to an individual, or participation by an individual or the family member of an individual in clinical research that includes genetic services.

(II) With regard to an individual who is pregnant, “genetic information” includes genetic information of the fetus carried by the pregnant individual. With regard to an individual or family member using reproductive technology, “genetic information” includes genetic information of any embryo legally held by an individual or family member.

(III) “Genetic information” does not include information about the sex or age of an individual.

(d) “Genetic services” means a genetic test, genetic counseling, which includes obtaining, interpreting, or assessing genetic information, or genetic education.

(e)(I) “Genetic test” means any analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes.

(II) “Genetic test” does not include:

(A) An analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved; or

(B) An analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes.

(f) “Underwriting purposes” means any of the following:

(I) Rules for, or determination of, eligibility for enrollment or continued eligibility in a policy or for benefits under the policy;

(II) The computation of premium or contribution amounts under the policy;

(III) The application of any preexisting condition exclusion under the policy; and

(IV) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(3)(a) Genetic information shall be confidential and privileged. Any release, for purposes other than diagnosis, treatment, or therapy, of genetic information that identifies the person tested with the test results released requires specific written consent by the person about whom the genetic information pertains or the parent or guardian of that person.

(b)(I) Any entity that receives genetic information may not seek, use, or keep the information for any nontherapeutic purpose or for any underwriting purpose connected with the provision of health care insurance or medicare supplement insurance coverage.

(II) If an entity obtains genetic information incidental to a request or requirement for, or purchase of, other information concerning an individual, the request or requirement for, or purchase of, such information shall not be considered a violation of this paragraph (b) if it is not in violation of paragraph (a) of this subsection (3).

(c)(I) An entity shall not request or require an individual or family member of the individual to undergo a genetic test unless otherwise authorized by applicable state or federal law.

(II) Nothing in this paragraph (c) shall be construed to preclude an entity from obtaining and using the results of a genetic test in making a determination regarding payment, as defined in 45 CFR 164.501, as may be amended, and consistent with paragraphs (a) and (b) of this subsection (3).

(4) Notwithstanding the provisions of subsection (3) of this section, in the course of a criminal investigation or a criminal prosecution, and to the extent allowed under the federal or state constitution, any peace officer, district attorney, or assistant attorney general, or a designee thereof, may obtain genetic information regarding the identity of any individual who is the subject of the criminal investigation or prosecution for use exclusively in any criminal investigation or prosecution without the consent of the individual being tested.

(5) Notwithstanding the provisions of subsection (3) of this section, any research facility may use genetic information for scientific research purposes if the identity of any individual to whom the information pertains is not disclosed to any third party; except that the individual's identity may be disclosed to the individual's physician if the individual consents to the disclosure in writing.

(6) This section does not limit the authority of a court or any party to a parentage proceeding to use genetic information for purposes of determining parentage pursuant to section 13-25-126, C.R.S.

(7) This section does not limit the authority of a court or any party to a proceeding that is subject to the limitations of part 5 of article 64 of title 13, C.R.S., to use genetic information for purposes of determining the cause of damage or injury.

(8) This section does not limit the authority of the state board of parole to require any offender who is involved in a sexual assault to submit to blood tests and to retain the results of such tests on file as authorized under section 17-2-201(5)(g), C.R.S.

(9) This section does not limit the authority granted the state department of public health and environment, the state board of health, or county, district, or municipal public health agencies pursuant to section 25-1-122, C.R.S.

(10) Any violation of this section is an unfair practice as defined in section 10-3-1104(1), and is subject to the provisions of sections 10-3-1106 to 10-3-1113.

(11) Any individual who is injured by an entity's violation of this section may recover in a court of competent jurisdiction the following remedies:

(a) Equitable relief, which may include a retroactive order, directing the entity to provide health insurance or medicare supplement insurance coverage, whichever is appropriate, to the injured individual under the same terms and conditions as would have applied had the violation not occurred; and

(b) The greater of:

(I) An amount equal to any actual damages suffered by the individual as a result of the violation; or

(II) Ten thousand dollars per violation.

(12) The prevailing party in an action under this section may recover costs and reasonable attorney fees.

Credits

Added by Laws 2009, Ch. 353, § 2, eff. July 1, 2009. Amended by Laws 2010, Ch. 419, § 14, eff. Aug. 11, 2010.

C. R. S. A. § 10-3-1104.6, CO ST § 10-3-1104.6

Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1104.7

§ 10-3-1104.7. Genetic testing--legislative declaration--definitions--limitations on disclosure of information--liability

Effective: July 1, 2009
Currentness

(1) The general assembly hereby finds and determines that recent advances in genetic science have led to improvements in the diagnosis, treatment, and understanding of a significant number of human diseases. The general assembly further declares that:

(a) Genetic information is the unique property of the individual to whom the information pertains;

(b) Any information concerning an individual obtained through the use of genetic techniques may be subject to abuses if disclosed to unauthorized third parties without the willing consent of the individual to whom the information pertains;

(c) To protect individual privacy and to preserve individual autonomy with regard to the individual's genetic information, it is appropriate to limit the use and availability of genetic information;

(d) The intent of this section is to prevent information derived from genetic testing from being used to deny access to group disability insurance or long-term care insurance coverage.

(2) For the purposes of this section:

(a) “Entity” means any entity that provides group disability insurance or long-term care insurance coverage and is subject to the jurisdiction of the commissioner of insurance.

(b) “Genetic testing” means any laboratory test of human DNA, RNA, or chromosomes that is used to identify the presence or absence of alterations in genetic material which are associated with disease or illness. “Genetic testing” includes only such tests as are direct measures of such alterations rather than indirect manifestations thereof.

(3)(a) Information derived from genetic testing shall be confidential and privileged. Any release, for purposes other than diagnosis, treatment, or therapy, of genetic testing information that identifies the person tested with the test results released requires specific written consent by the person tested.

(b) Any entity that receives information derived from genetic testing may not seek, use, or keep the information for any nontherapeutic purpose or for any underwriting purpose connected with the provision of group disability insurance or long-term care insurance coverage.

(4) Notwithstanding the provisions of subsection (3) of this section, in the course of a criminal investigation or a criminal prosecution, and to the extent allowed under the federal or state constitution, any peace officer, district attorney, or assistant attorney general, or a designee thereof, may obtain information derived from genetic testing regarding the identity of any individual who is the subject of the criminal investigation or prosecution for use exclusively in the criminal investigation or prosecution without the consent of the individual being tested.

(5) Notwithstanding the provisions of subsection (3) of this section, any research facility may use the information derived from genetic testing for scientific research purposes so long as the identity of any individual to whom the information pertains is not disclosed to any third party; except that the individual's identity may be disclosed to the individual's physician if the individual consents to such disclosure in writing.

(6) This section does not limit the authority of a court or any party to a parentage proceeding to use information obtained from genetic testing for purposes of determining parentage pursuant to section 13-25-126, C.R.S.

(7) This section does not limit the authority of a court or any party to a proceeding that is subject to the limitations of part 5 of article 64 of title 13, C.R.S. [1], to use information obtained from genetic testing for purposes of determining the cause of damage or injury.

(8) This section does not limit the authority of the state board of parole to require any offender who is involved in a sexual assault to submit to blood tests and to retain the results of such tests on file as authorized under section 17-2-201(5)(g), C.R.S.

(9) This section does not limit the authority granted the state department of public health and environment, the state board of health, or local departments of health pursuant to section 25-1-122, C.R.S.

(10) Notwithstanding any provision of this section to the contrary, the only requirements that shall apply to an insurer in connection with life insurance or individual disability insurance are as follows:

(a) Except as otherwise specifically authorized or required by another section of state or federal law, an insurer shall not require the performance of or perform a genetic test without first receiving the specific, written, informed consent of the subject of the test who has the capacity to consent or, if the person subject to the test lacks the capacity to consent, of a person authorized by law to consent on behalf of the subject of the test. Written consent shall be in a form prescribed by the commissioner.

(b) The results of a genetic test performed pursuant to this subsection (10) are privileged and confidential and shall not be released to any person except as specifically authorized under applicable state or federal law.

(11) Any violation of this section is an “unfair practice”, as defined in section 10-3-1104(1), and is subject to the provisions of sections 10-3-1106 to 10-3-1113.

(12) Any individual who is injured by an entity's violation of this section may recover in a court of competent jurisdiction the following remedies:

(a) Equitable relief, which may include a retroactive order, directing the entity to provide group disability insurance or long-term care insurance coverage, whichever is appropriate, to the injured individual under the same terms and conditions as would have applied had the violation not occurred; and

(b) The greater of:

(I) An amount equal to any actual damages suffered by the individual as a result of the violation; or

(II) Ten thousand dollars per violation.

(13) The prevailing party in an action under this section may recover costs and reasonable attorney fees.

Credits

Added by Laws 1994, S.B.94-58, § 1, eff. June 2, 1994. Amended by Laws 1994, H.B.94-1029, § 22, eff. July 1, 1994; Laws 2002, Ch. 262, § 1, eff. June 1, 2002; Laws 2003, Ch. 315, § 7, eff. May 22, 2003; Laws 2009, Ch. 353, § 1, eff. July 1, 2009.

Footnotes

1 Section 13-64-501 et seq.

C. R. S. A. § 10-3-1104.7, CO ST § 10-3-1104.7

Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1104.8

§ 10-3-1104.8. Domestic abuse discrimination--prohibited

Currentness

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

(a) "Domestic abuse" means the occurrence of one or more of the following acts between family members, current or former household members, or persons who are or have been involved in an intimate relationship:

(I) Committing an act of unlawful sexual behavior, as described in part 4 of article 3 of title 18, C.R.S., or otherwise intentionally, knowingly, or recklessly causing or attempting to cause another person, including a minor, bodily injury or physical or psychological harm; or

(II) Knowingly engaging in repeated acts under circumstances that place the person toward which such acts are directed in reasonable fear of bodily injury or physical or psychological harm; or

(III) Subjecting another person to false imprisonment; or

(IV) Intentionally, knowingly, or recklessly causing or attempting to cause damage to property so as to intimidate or attempt to control the behavior of another person.

(b) "Domestic abuse related medical condition" means a medical condition sustained by a victim of domestic abuse that arises in whole or in part out of an act or pattern of domestic abuse.

(c) "Domestic abuse status" means the fact or perception that a person is or has been a victim of domestic abuse, irrespective of whether the person has sustained a domestic abuse related medical condition.

(d) "Victim of domestic abuse" means a person against whom any of the acts specified in paragraph (a) of this subsection (1) has been directed by any of the persons specified in said paragraph (a).

(2) The following are unfair methods of competition and unfair or deceptive acts or practices in the business of insurance by insurers licensed in this state, their employees, or their producers:

(a) Denying, refusing to issue, refusing to renew, refusing to reissue, canceling, or otherwise terminating an insurance policy or restricting coverage on any person solely because of that person's domestic abuse status; or

(b) Adding any surcharge or rating factor to a premium of an insurance policy solely because of an insured's domestic abuse status; or

(c) Directly or indirectly asking an insured or an insurance applicant about that person's domestic abuse status unless related to the provision of appropriate medical or mental health services to an insured as provided by the insurance contract or health maintenance organization, but said information shall not be released without specific, separate authorization from the insured; or

(d) Disclosing or transferring by insurers licensed in this state, their employees, or their producers any information relating to a person's domestic abuse status or a person's domestic abuse related medical condition as it relates to a person's family, household, social, or employment relationship with a victim of domestic abuse, except:

(I) To the extent required in the ordinary course of business and consistent with paragraph (a), (b), or (c) of this subsection (2);

(II) To the extent required for compliance with domestic abuse reporting laws or with an order of a court of competent jurisdiction; or

(III) At the written request of the commissioner for the purpose of determining the insurer's compliance with this section. This paragraph (d) shall not preclude a victim of domestic abuse from obtaining his or her records, including medical records.

(3) An insurer that takes an action that adversely affects an insured or an applicant who is a victim of domestic abuse, shall demonstrate to the applicant or the insured, upon the written request of the insured or applicant, that such action is not based solely upon the domestic abuse status of the insured or the applicant but that the action is based on underwriting criteria related to the condition, property, or claim history of the insured or the applicant and that the decision to take such action was based on sound underwriting and actuarial principles related to actual or anticipated loss experience.

(4) An insurer that complies with this section and acts in good faith shall not be held civilly liable in any cause of action that may be brought because of compliance with this section.

(5) Nothing in this section shall be construed to alter or modify any policy conditions, exclusions, or limitations that are consistent with paragraphs (a), (b), and (c) of subsection (2) of this section and are clearly stated in the contract.

(6) Nothing in this section shall be construed to establish a protected class for victims of domestic abuse.

Credits
Added by Laws 1997, S.B.97-72, § 1, eff. Jan. 1, 1998.

C. R. S. A. § 10-3-1104.8, CO ST § 10-3-1104.8

Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1105

§ 10-3-1105. Favored agent or insurer--coercion of debtors

Currentness

(1) No person may:

(a) Require, as a condition precedent to the lending of money, or extension of credit, or to entering into any lease transaction, or any renewal of any of them, that the person to whom such money or credit is extended, or the lessee, or the person whose obligation the creditor is to acquire or finance negotiate any policy or contract of insurance through a particular insurer or group of insurers or agent or broker or group of agents or brokers;

(b) Unreasonably disapprove the insurance policy provided by a borrower or lessee for the protection of the property securing the credit, or lien, or which is the subject of the lease. For the purposes of this paragraph (b), disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required; or

(c) Require directly or indirectly that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge in connection with the handling of any insurance policy required as security for a loan on real estate, or pay a separate charge to substitute the insurance policy of one insurer for that of another. The provisions of this paragraph (c) shall not apply to the interest which may be charged on premium loans or premium advancements in accordance with the security instrument.

(2) The commissioner may investigate the affairs of any person to whom this section applies to determine whether such person has violated the provisions of this section. If a violation of this section is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of this part 11.

(3) For the purposes of this section, “person” includes any individual, corporation, association, partnership, or other legal entity.

Credits
Amended by Laws 1985, H.B.1245, § 13, eff. May 10, 1985.

Notes of Decisions (1)

C. R. S. A. § 10-3-1105, CO ST § 10-3-1105
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1106

§ 10-3-1106. Power of commissioner

Currentness

The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by this part 11.

Notes of Decisions (1)

C. R. S. A. § 10-3-1106, CO ST § 10-3-1106
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1107

§ 10-3-1107. Hearings

Currentness

Whenever the commissioner has reason to believe that any person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice, whether defined or reasonably implied in this part 11, or has violated any other provision of this title or any rule or lawful order of the commissioner and that a proceeding by the commissioner in respect thereto would be to the interest of the public, the commissioner shall proceed as provided in article 4 of title 24, C.R.S. Any final action by the commissioner pursuant to this section shall be subject to judicial review by the court of appeals pursuant to section 24-4-106(11), C.R.S.

Credits

Amended by Laws 1992, S.B.92-90, § 53, eff. May 20, 1992; Laws 1997, S.B.97-108, § 3, eff. July 1, 1997.

C. R. S. A. § 10-3-1107, CO ST § 10-3-1107

Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1108

§ 10-3-1108. Orders

Effective: August 5, 2008
Currentness

(1) If, after a hearing conducted under section 10-3-1107, the commissioner determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice or has violated any other provision of this title or any rule or lawful order of the commissioner, the commissioner shall reduce the findings to writing and shall issue and cause to be served on such person a copy of such findings and an order requiring such person to cease and desist from engaging in such method of competition, act, practice, or violation, and, except in the case of an act or practice that is not a violation of any specific provision of this title or any specific rule or lawful order of the commissioner, the commissioner may, at his or her discretion, order any one or more of the following:

(a) Payment of a monetary penalty of not more than three thousand dollars for each act or violation but not to exceed an aggregate penalty of thirty thousand dollars, unless such person, being an insurer, knew or reasonably should have known he or she was in violation of this part 11, in which case the penalty shall not be more than thirty thousand dollars for each act or violation, but not to exceed an aggregate penalty of seven hundred fifty thousand dollars annually;

(b) Suspension or revocation of the person's license if he knew or reasonably should have known he was in violation of the provisions of this part 11; or

(c) Payment of a contractual claim to an insured or beneficiary pursuant to an insurance policy if the commissioner finds that the violation of this part 11 caused the failure to pay the claim, which amount shall be determined by the commissioner at the hearing based on the testimony and evidence presented. This paragraph (c) shall not apply during the pendency of any civil action seeking a declaratory judgment concerning such claims.

(2) Any order issued by the commissioner pursuant to paragraph (c) of subsection (1) of this section may be appealed to the district court, whereupon the matter shall be tried de novo by the district court.

Credits
Amended by Laws 1981, H.B.1256, § 4, eff. June 4, 1981; Laws 1990, H.B.90-1079, §§ 1, 2, eff. April 5, 1990; Laws 1993, H.B.93-1207, § 2, eff. July 1, 1993; Laws 1994, S.B.94-58, § 2, eff. June 2, 1994; Laws 1994, S.B.94-206, § 23, eff. May 31, 1994; Laws 1997, S.B.97-108, § 4, eff. July 1, 1997; Laws 2008, Ch. 422, § 3, eff. Aug. 5, 2008.

Notes of Decisions (2)

C. R. S. A. § 10-3-1108, CO ST § 10-3-1108
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1109

§ 10-3-1109. Penalty for violation of cease-and-desist orders

Currentness

(1) Any person who violates a cease-and-desist order of the commissioner issued under section 10-3-1108, and while such order is in effect, may, after notice and hearing and upon order of the commissioner, be subject, at the discretion of the commissioner, to any one or more of the following:

(a) A monetary penalty of not more than ten thousand dollars for each and every act or violation of an insurer; or a monetary penalty of not more than five hundred dollars for each and every act or violation of an individual;

(b) Suspension or revocation of such person's license.

C. R. S. A. § 10-3-1109, CO ST § 10-3-1109
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1110

§ 10-3-1110. Rules

Currentness

(1) The commissioner may, after notice and hearing, as provided in article 4 of title 24, C.R.S., promulgate reasonable rules and regulations as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by sections 10-3-1104 and 10-3-1105.

(2) The commissioner may, after notice and hearing, as provided in article 4 of title 24, C.R.S., promulgate rules with respect to the payment of benefits under group and individual contracts of property or casualty coverage, issued by organizations authorized to do business in this state under the provisions of article 4 of this title; except that, to the extent that a provision of this subsection (2) conflicts with section 10-4-642, as enacted by senate bill 04-125, enacted at the second regular session of the sixty-fourth general assembly, the provisions of said section 10-4-642 shall govern. Such rules may establish a penalty payable to the claimant on benefit payments that are delayed more than sixty days after a valid and complete filing of the claim unless there is a reasonable dispute between the parties concerning such claim. Such penalty shall not exceed twenty dollars on claims of less than one hundred dollars or interest at a rate of eight percent annually on claims above one hundred dollars. In addition to such penalties payable to the claimant, the commissioner, after notice and hearing, may assess a civil penalty against any insurer of one hundred dollars per day for each day benefit payments are delayed more than sixty days after a valid and complete filing of the claim unless there is a reasonable dispute between the parties concerning such claim.

(3) Deleted by Laws 1999, Ch. 285, § 2, eff. Jan. 1, 2000.

Credits

Amended by Laws 1984, H.B.1377, § 2, eff. July 1, 1984; Laws 1990, H.B.90-1079, § 3, eff. April 5, 1990; Laws 1991, S.B.91-243, § 10, eff. June 1, 1991; Laws 1992, S.B.92-90, § 54, eff. May 20, 1992; Laws 1992, S.B.92-104, § 6, eff. July 1, 1992; Laws 1999, Ch. 285, § 2, eff. Jan. 1, 2000; Laws 2003, Ch. 234, § 5, eff. July 1, 2003; Laws 2004, Ch. 255, § 2, eff. May 21, 2004; Laws 2004, Ch. 295, § 3, eff. July 1, 2004.

Notes of Decisions (4)

C. R. S. A. § 10-3-1110, CO ST § 10-3-1110
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1111

§ 10-3-1111. Provisions of part 11 additional to existing law

Currentness

The powers vested in the commissioner by this part 11 shall be additional to any other powers to enforce any monetary or other penalties or forfeitures authorized by law with respect to the methods, acts, and practices declared in this part 11 to be unfair or deceptive.

C. R. S. A. § 10-3-1111, CO ST § 10-3-1111
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

End of Document

Title 10. Insurance (Refs & Annos)
Regulation of Insurance Companies
Article 3. Regulation of Insurance Companies (Refs & Annos)
Part 11. Unfair Competition--Deceptive Practices (Refs & Annos)

C.R.S.A. § 10-3-1112

§ 10-3-1112. Immunity from prosecution

Currentness

(1) If any person asks to be excused from attending and testifying or from producing any books, papers, records, correspondence, or other documents at any hearing on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture and, notwithstanding, is directed to give such testimony or produce such evidence, he must comply with such direction; but he shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which he may testify or produce evidence pursuant thereto; and no testimony so given or evidence so produced shall be received against him upon any criminal action, investigation, or proceeding. No such individual so testifying may be exempt from prosecution or punishment for perjury in the first degree committed by him while so testifying, and the testimony or evidence so given or produced shall be admissible against him upon any criminal action, investigation, or proceeding concerning such perjury; nor may he be exempt from the refusal, revocation, or suspension of any license, permission, or authority conferred, or to be conferred, pursuant to the insurance law of this state.

(2) Any such individual may execute, acknowledge, and file in the office of the commissioner a statement expressly waiving such immunity or privilege in respect to any transaction, matter, or thing specified in such statement and thereupon the testimony of such person or such evidence in relation to such transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, grand jury, or otherwise, and if so received or produced such individual shall not be entitled to any immunity or privilege on account of any testimony he may so give or evidence so produced.

C. R. S. A. § 10-3-1112, CO ST § 10-3-1112
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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C.R.S.A. § 10-3-1113

§ 10-3-1113. Information to trier of fact in civil actions

Currentness

(1) In any civil action for damages founded upon contract, or tort, or both against an insurance company, the trier of fact may be instructed that the insurer owes its insured the duty of good faith and fair dealing, which duty is breached if the insurer delays or denies payment without a reasonable basis for its delay or denial.

(2) Under a policy of liability insurance, the determination of whether the insurer's delay or denial was reasonable shall be based on whether the insurer's delay or denial was negligent.

(3) Under a policy of first-party insurance, the determination of whether the insurer's delay or denial was reasonable shall be based on whether the insurer knew that its delay or denial was unreasonable or whether the insurer recklessly disregarded the fact that its delay or denial was unreasonable.

(4) In determining whether an insurer's delay or denial was reasonable, the jury may be instructed that willful conduct of the kind set forth in section 10-3-1104(1)(h)(I) to (1)(h)(XIV) is prohibited and may be considered if the delay or denial and the claimed injury, damage, or loss was caused by or contributed to by such prohibited conduct.

Credits
Amended by Laws 1987, S.B.67, § 1, eff. July 1, 1987.

Notes of Decisions (23)

C. R. S. A. § 10-3-1113, CO ST § 10-3-1113
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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Title 10. Insurance (Refs & Annos)
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C.R.S.A. § 10-3-1114

§ 10-3-1114. Construction of part 11

Effective: August 5, 2008
Currentness

Except as provided in sections 10-3-1115 and 10-3-1116, nothing in this part 11 shall be construed to create a private cause of action based on alleged violations of this part 11 or to abrogate any common law contract or tort cause of action.

Credits
Amended by Laws 1987, S.B.67, § 1, eff. July 1, 1987; Laws 2008, Ch. 422, § 4, eff. Aug. 5, 2008.

Notes of Decisions (7)

C. R. S. A. § 10-3-1114, CO ST § 10-3-1114
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

End of Document

KeyCite Red Flag - Severe Negative Treatment
Enacted Legislation **Amended by** 2016 Colo. Legis. Serv. Ch. 157 (H.B. 16-1165) (WEST),

Title 10. Insurance (Refs & Annos)
Regulation of Insurance Companies
Article 3. Regulation of Insurance Companies (Refs & Annos)
Part 11. Unfair Competition--Deceptive Practices (Refs & Annos)

C.R.S.A. § 10-3-1115

§ 10-3-1115. Improper denial of claims--prohibited--definitions--severability

Effective: August 5, 2008
Currentness

(1)(a) A person engaged in the business of insurance shall not unreasonably delay or deny payment of a claim for benefits owed to or on behalf of any first-party claimant.

(b) For the purposes of this section and section 10-3-1116:

(I) "First-party claimant" means an individual, corporation, association, partnership, or other legal entity asserting an entitlement to benefits owed directly to or on behalf of an insured under an insurance policy. "First-party claimant" includes a public entity that has paid a claim for benefits due to an insurer's unreasonable delay or denial of the claim.

(II) "First-party claimant" does not include:

(A) A nonparticipating provider performing services; or

(B) A person asserting a claim against an insured under a liability policy.

(2) Notwithstanding section 10-3-1113(3), for the purposes of an action brought pursuant to this section and section 10-3-1116, an insurer's delay or denial was unreasonable if the insurer delayed or denied authorizing payment of a covered benefit without a reasonable basis for that action.

(3) If any provision of this section or its application to any person or circumstance is held illegal, invalid, or unenforceable, no other provisions or applications of this section shall be affected that can be given effect without the illegal, invalid, or unenforceable provision or application, and to this end the provisions of this section are severable.

(4) The general assembly declares that this section is a law regulating insurance.

(5) This section and section 10-3-1116 shall not apply to insurance issued in compliance with the “Workers' Compensation Act of Colorado”, articles 40 to 47 of title 8, C.R.S.

(6) This section and section 10-3-1116 shall not apply to title insurance issued pursuant to article 11 of this title or to life insurance issued pursuant to article 7 of this title.

Credits
Added by Laws 2008, Ch. 422, § 5, eff. Aug. 5, 2008.

Notes of Decisions (50)

C. R. S. A. § 10-3-1115, CO ST § 10-3-1115
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

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Title 10. Insurance (Refs & Annos)
Regulation of Insurance Companies
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Part 11. Unfair Competition--Deceptive Practices (Refs & Annos)

C.R.S.A. § 10-3-1116

§ 10-3-1116. Remedies for unreasonable delay or denial of benefits--required contract provision--frivolous actions--severability

Effective: August 5, 2008
Currentness

(1) A first-party claimant as defined in section 10-3-1115 whose claim for payment of benefits has been unreasonably delayed or denied may bring an action in a district court to recover reasonable attorney fees and court costs and two times the covered benefit.

(2) An insurance policy, insurance contract, or plan that is issued in this state that offers health or disability benefits shall not contain a provision purporting to reserve discretion to the insurer, plan administrator, or claim administrator to interpret the terms of the policy, contract, or plan or to determine eligibility for benefits.

(3) An insurance policy, insurance contract, or plan that is issued in this state shall provide that a person who claims health, life, or disability benefits, whose claim has been denied in whole or in part, and who has exhausted his or her administrative remedies shall be entitled to have his or her claim reviewed de novo in any court with jurisdiction and to a trial by jury.

(4) The action authorized in this section is in addition to, and does not limit or affect, other actions available by statute or common law, now or in the future. Damages awarded pursuant to this section shall not be recoverable in any other action or claim.

(5) If the court finds that an action brought pursuant to this section was frivolous as provided in article 17 of title 13, C.R.S., the court shall award costs and attorney fees to the defendant in the action.

(6) If any provision of this section or its application to any person or circumstance is held illegal, invalid, or unenforceable, no other provisions or applications of this section shall be affected that can be given effect without the illegal, invalid, or unenforceable provision or application, and to this end the provisions of this section are severable.

(7) The general assembly declares that this section is a law regulating insurance.

Credits
Added by Laws 2008, Ch. 422, § 5, eff. Aug. 5, 2008.

Notes of Decisions (81)

C. R. S. A. § 10-3-1116, CO ST § 10-3-1116
Current through laws effective April 22, 2016 of the Second Regular Session of the 70th General Assembly (2016), see scope for further details.

End of Document

Title 700. Department of Regulatory Agencies
702. Division of Insurance
3 CCR 702-5. Property and Casualty

3 CCR 702-5:5-1-14
3 Colo. Code Regs. 702-5:5-1-14Alternatively cited as 3 CO ADC 702-5

702-5:5-1-14. PENALTIES FOR FAILURE TO PROMPTLY ADDRESS PROPERTY AND CASUALTY FIRST PARTY CLAIMS

Currentness

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance pursuant to §§ 10-1-109 and 10-3-1110, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to describe the procedure and circumstances under which penalties will be imposed for failure to make timely decisions and/or payment on first party claims.

Section 3 Applicability

This rule shall apply to all insurers authorized to write property and casualty insurance in the state of Colorado.

Section 4 Rules

A. Timely Decisions and Payment of Benefits

1. Penalties

a. All insurers authorized to write property and casualty insurance policies in Colorado, shall make a decision on claims and/or pay benefits due under the policy within sixty (60) days after receipt of a valid and complete claim unless there is a reasonable dispute between the parties concerning such claim, and provided the insured has complied with the terms and conditions of the policy of insurance.

b. If an insurer fails to make a decision and/or pay benefits due under the policy within sixty (60) days after a valid and complete claim has been received, and there is not a reasonable dispute between the parties, and the insured has complied with the terms and conditions of the policy of insurance, the Commissioner of Insurance may impose the following penalties to be paid by the insurer to the insured:

(1) If the claim is $100.00 or less, the penalty shall not be more than $20.00;

(2) If the claim is more than $100.00, the penalty shall be 8 percent annual interest on the amount of benefits due, computed from the latest of the time a valid and complete claim is received, the reasonable dispute was resolved, or the insured complied with the terms and conditions of the policy, until the time the benefits due are paid by the insurer.

c. In addition to such penalties payable to the claimant, the Commissioner of Insurance, after notice and hearing, may assess a civil penalty against any insurer of $100.00 per day for each day benefit payments are delayed more than sixty (60) days after a valid and complete filing of the claim unless there is a reasonable dispute between the parties concerning such claim.

2. Conditions

a. A valid and complete claim is deemed received by the insurer when:

(1) All information and documents necessary to prove the insured's claim have been received by the insurer;

(2) A reasonable investigation of the information submitted has been completed by the insurer, in compliance with § 10-3-1104, C.R.S.;

(3) The terms and conditions of the policy have been complied with by the insured;

(4) Coverage under the policy for the insured has been established for the claim submitted;

(5) There are no indicators on the claim requiring additional investigation before a decision can be made; and/or

(6) All repairs have been satisfactorily completed and the insured has given authorization to pay; and/or

(7) Negotiations or appraisals to determine the value of the claim have been completed; and/or

(8) Any litigation on the claim has been finally and fully adjudicated.

b. A reasonable dispute may include, but is not limited to:

(1) Information necessary to make a decision on the claim has not been submitted or obtained;

(2) Conflicting information is submitted or obtained and additional investigation is necessary;

(3) The insured is not in compliance with the terms and conditions of the policy;

(4) Coverage under the policy for the loss claimed has not been determined;

(5) Indicators are present in the application or submission of the claim and additional investigation is necessary;

(6) Litigation is commenced on the claim; or

(7) Negotiations or appraisals are in process to determine the value of a claim.

3. A good faith offer by the insurer to the insured within sixty (60) days after the receipt of a valid and complete claim satisfies the requirements under this regulation.

4. If claims for benefits are processed by a third party administrator or other entity acting on behalf of the insurer, or if the insured is represented by a third party, the failure of the third party to comply with the terms of the policy or this regulation, shall be the failure of the insurer or insured respectively.

5. In all actions initiated under this regulation, the insured shall have the burden of proving to the Commissioner of Insurance that he/she submitted a valid and complete claim to the insurer.

6. The insurer shall have the burden of proving to the Commissioner of Insurance that a reasonable dispute existed.

7. If it is determined that benefits are due to the insured, the insurer must issue a payment to the insured within sixty (60) days of a valid and complete claim being received, if all the conditions in the definition herein are met.

8. In the event of a significant catastrophe resulting in multiple claims, an insurer may notify the Commissioner of Insurance of the nature and extent of the catastrophe and request a deviation or exemption from this regulation.

B. Reasonable Investigation

1. The Commissioner of Insurance recognizes that the scope of an investigation can be determined, in part, to be reasonable based on the terms and conditions of the policy and the facts and circumstances of each claim. It may include, but is not limited to:

a. Reports from police or other law or fire enforcement authorities;

b. Scene investigations;

c. Photographs, videotaped evidence;

d. Surveillance information;

e. Statements or reports from the insureds, claimants, other parties, witnesses, or anyone who may have knowledge of elements of the claim;

f. Repair estimates;

g. Reports from relevant experts;

h. Credit reports and financial information;

i. Information on prior, concurrent or subsequent claims; or

j. Other relevant information.

2. Documentation that a reasonable investigation has been conducted shall be maintained in the claim file. Such documentation may include, but is not limited to:

a. Adjuster's log notes;

b. Copies of written communications;

c. Written reports used in the investigation of a claim;

d. Status reports;

e. Evidence of payments; or

f. Other relevant information.

3. When an investigation is incomplete or is otherwise continued and the insurer has not paid the claim within the time required under section 4.A.1. above, the insurer shall immediately notify the insured or the insured's representative, if applicable, of the reason(s) the claim has not been paid. Additionally, if the claim is not paid within the time requirement under section 4.A.1., above, the insurer shall, every thirty (30) days thereafter, send to the insured or the insured's representative a letter setting forth the reason(s) additional time is needed for investigation. This requirement is not intended

to alter any terms of the contract between the insurer and insured regarding their respective rights, duties, and obligations and the law involving such matters.

4. If the claim has not been paid because an investigation is underway, the insurer shall document in the claim file the actions being taken to investigate the claim and the efforts being made to promptly conclude the investigation.

5. The claim file documentation required by this regulation will be reviewed by the Division of Insurance during an investigation of a complaint or during a market conduct examination to determine if the requirements of § 10-3-1104(1)(h), C.R.S. and this regulation have been met.

Section 5 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 6 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 7 Effective Date

This regulation shall become effective on September 1, 2012.

Section 8 History

New regulation 5-1-14 effective May 1, 2001.

Amended regulation effective December 1, 2001.

Amended regulation effective February 1, 2004.

Amended regulation effective September 1, 2012.

Credits
Amended Sept. 1, 2012.

Current through CR, Vol. 39, No. 9, May 10, 2016.

3 CCR 702-5:5-1-14, 3 CO ADC 702-5:5-1-14

End of Document