C.R.S. Title 10, Art. 20

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

Article 20. Life and Health Insurance Protection Association

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C.R.S. 10-20-101

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10-20-101. Short title.

The short title of this article 20 is the “Life and Health Insurance Protection Association Act”.

History

Source:L. 91: Entire article added, p. 1256, § 1, effective July 1.**L. 2023:**Entire section amended, *(HB 23-1303), ch. 195, p. 978, § 2*, effective May 15.

End of Document

C.R.S. 10-20-102

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-102. Legislative declaration.

(1) The general assembly finds and declares that the purpose of this article 20 is to protect, subject to certain limitations, the persons specified in section 10-20-104 (1) against failure by member insurers in the performance of their contractual obligations under life insurance policies, health insurance policies, health benefit plans, and annuity policies, plans, or contracts specified in section 10-20-104 (2) because of the insolvency of the member insurer that issued the policies, plans, or contracts.

(2) To provide the protection specified in subsection (1) of this section, an association of member insurers shall be created and shall exist to pay benefits and to continue coverages as limited pursuant to this article 20. Member insurers of the association are subject to assessment to provide funds to carry out the purpose of this article 20.

History

Source:L. 91: Entire article added, p. 1256, § 1, effective July 1.**L. 2023:**Entire section amended, *(HB 23-1303), ch. 195, p. 978, § 3*, effective May 15.

End of Document

C.R.S. 10-20-103

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-103. Definitions.

As used in this article 20, unless the context otherwise requires:

(1) "Account" means any of the three accounts created pursuant to section 10-20-106.

(2) "Association" means the life and health insurance protection association as established by this article.

(2.5)"Authorized assessment" or "authorized" when used in the context of assessments means a resolution passed by the board in which an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution pertaining to the assessment is passed.

(3) "Board" means the board of the association.

(3.5)"Called assessment" or "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid by the date set in the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

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

(5) "Contractual obligation" means any obligation under a policy, contract, or certificate under a group policy or contract, or portion thereof, for which coverage is provided pursuant to section 10-20-104.

(6) "Covered policy", "covered contract", or "covered policy or contract" means a policy or contract, or a portion of a policy or contract, for which coverage is provided under section 10-20-104.

(6.5)"Extracontractual claims" includes claims relating to bad faith in the payment of claims, claims for punitive or exemplary damages, and claims for attorney fees and costs.

(6.6)

(a) "Health benefit plan" means any hospital or medical expense policy or certificate, health maintenance organization subscriber contract, or other similar health contract that is subject to the jurisdiction of the commissioner and available for use, offered, or sold in Colorado.

(b) "Health benefit plan" does not include:

(I) An accident only plan;

(II) Credit insurance;

(III) Dental insurance;

(IV) Vision insurance;

(V) A medicare supplement plan;

(VI) Benefits for long-term care, home health care, community-based care, or any combination of such benefits;

(VII) Disability income insurance;

(VIII) Liability insurance including general liability insurance and automobile liability insurance;

(IX) Coverage for on-site medical clinics;

(X) Coverage issued as a supplement to liability insurance, workers' compensation, or similar insurance;

(XI) Automobile medical payment insurance; or

(XII) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the type of coverage does not provide coordination of benefits and is provided under a separate policy or certificate.

(6.7)"Impaired insurer" means a member insurer that is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(7) "Insolvent insurer" means a member insurer which after July 1, 1991, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(8) "Member insurer" means any insurer or health maintenance organization that is licensed or holds a certificate of authority in this state to write any kind of insurance or health maintenance organization business for which coverage is provided pursuant to section 10-20-104 and includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn. "Member insurer" does not include:

(a) A nonprofit hospital or medical service organization;

(b) Repealed.

(c) A fraternal benefit society;

(d) A mandatory state pooling plan;

(e) Repealed.

(f) A stipulated premium insurance company;

(g) A local mutual burial association;

(h) A mutual assessment company or any entity that operates on an assessment basis;

(i) An interinsurance exchange;

(i.5)A health-care coverage cooperative with a certificate of authority issued and operating under part 10 of article 16 of this title 10; or

(j) Any entity similar to those specified in subsections (8)(a) to (8)(i.5) of this section.

(9) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(10) "NAIC" means the national association of insurance commissioners.

(10.5) "Owner" of a policy or contract, "policy owner", "policyholder", "contract holder", or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms "owner", "contract owner", "policyholder", "contract holder", and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

(11) "Person" means any individual, corporation, limited liability company, partnership, association, or voluntary organization.

(12)

(a) "Premiums" means the amount of money or other consideration, however designated, received on covered policies or contracts less returned premiums, returned consideration, and returned deposits, and less dividends and experience credits.

(b) "Premiums" does not include:

(I) Any amount of money or other consideration received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 10-20-104 (2); except that assessable premiums shall not be reduced on account of section 10-20-104 (2)(b)(III) relating to interest limitations and section 10-20-104 (3)(b) relating to limitations with respect to any one life;

(II) Premiums on an unallocated annuity contract; or

(III) Premiums in excess of five million dollars with respect to multiple nongroup policies of life insurance owned by one owner, regardless of:

(A) Whether the policy owner is an individual, firm, corporation, or other person;

(B) Whether the persons insured are officers, managers, employees, or other persons; or

(C) The number of policies or contracts held by the owner.

(12.5)

(a) "Principal place of business" of a person other than an individual means the single state in which the individuals who establish policy for the direction, control, and coordination of the operation of the entity as a whole primarily exercise that function, as determined by the association in its reasonable judgment by considering the following factors:

(I) The state in which the primary executive and administrative headquarters of the entity is located;

(II) The state in which the principal office of the chief executive officer of the entity is located;

(III) The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;

(IV) The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; and

(V) The state from which the overall operation of the entity is directed.

(b) In the case of plan sponsors, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state is the principal place of business for the plan sponsor.

(c) The principal place of business of a plan sponsor of a benefit plan is the principal place of business of the association, committee, joint board of trustees, or similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, is the principal place of business of the employer or employee organization that has the largest investment in the benefit plan.

(12.7) "Receivership court" means the court in an impaired or insolvent insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

(13) "Resident" means any person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person must be a resident of only one state, which, in the case of a person other than a natural person, must be its principal place of business. Citizens of the United States who are residents of a foreign country, United States possession, United States territory, or United States protectorate, which country, possession, territory, or protectorate does not have an association similar to the association created by this article

20, are deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(13.3) "State" means a state, the District of Columbia, Puerto Rico, or a possession, territory, or protectorate of the United States.

(13.5) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(14) "Supplemental contract" means any written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or a life, health, or annuity contract.

(15) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

History

Source:L. 91: Entire article added, p. 1257, § 1, effective July 1.**L. 2000:**(10.5), (13.5), and (15) added and (13) amended, p. 1017, § 1, effective July 1.**L. 2001:**(8)(e) amended, p. 1051, § 38, effective July 1.**L. 2004:**(8)(i) amended and (8)(i.5) added, p. 1009, § 15, effective August 4.**L. 2013:**(2.5), (3.5), (6.5), (6.7), (12.5), (12.7), and (13.3) added and (6), (9), (11), (12), (13), and (14) amended,*(SB 13-032), ch. 34, p. 81, § 1*, effective March 15; (8)(e) amended,*(HB 13-1115), ch. 338, p. 1973, § 14*, effective May 28.**L. 2023:**IP, (6), IP(8), (8)(i.5), (8)(j), (10.5), (12), (12.7), and (13) amended, (6.6) added, and (8)(b) repealed,*(HB 23-1303), ch. 195, p. 978, § 4*, effective May 15.

End of Document

C.R.S. 10-20-104

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-104. Coverage and limitations - coordination of benefits.

(1) This article 20 provides coverage for the policies and contracts specified in subsection (2) of this section and to persons:

(a) Who are owners of, certificate holders under, or enrollees in such policies or contracts, other than structured settlement annuities, and who:

(I) Are residents; or

(II) Are not residents, but only under all of the following conditions:

(A) The member insurer that issued the policies or contracts is domiciled in this state;

(B) The member insurer never held a license or certificate of authority in the states in which such persons reside;

(C) Such states have associations similar to the association created by this article; and

(D) Such persons are not eligible for any amount of coverage by such associations;

(b) Regardless of where they reside, except for nonresident certificate holders under group policies or contracts, who are the beneficiaries, assignees, or payees, including health-care providers rendering services under a health insurance or health maintenance organization policy, contract, or certificate, of the persons covered under subsection (1)(a) of this section.

(1.3) Subsection (1) of this section shall not apply to structured settlement annuities. Except as otherwise provided in subsections (1.5) and (1.7) of this section, this article shall provide coverage to a person who is a payee under a structured settlement annuity or to a beneficiary of a deceased payee if the payee:

(a) Is a resident, regardless of where the contract owner resides; or

(b) Is not a resident, but only under both of the following conditions:

(I) Either:

(A) The contract owner of the structured settlement annuity is a resident; or

(B) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by this article; and

(II) Neither the payee, the beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(1.5) This article 20 does not provide coverage to a person that:

(a) Is a payee or beneficiary of an owner or enrollee who is a resident of this state if the payee or beneficiary is afforded any coverage by the association of another state; or

(b) Acquires rights to receive payments through a structured settlement factoring transaction, as defined in 26 U.S.C. sec. 5891 (c)(3)(A), regardless of whether the transaction occurred before, on, or after the effective date of 26 U.S.C. sec. 5891 (c)(3)(A).

(1.7) This article 20 is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this article 20 is provided coverage under the laws of any other state, the person shall not be provided coverage under this article 20. In determining the application of the provisions of this subsection (1.7) in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, enrollee, or assignee, this article 20 shall be construed in conjunction with other state laws to result in coverage by only one association.

(2)

(a) This article 20 provides coverage to the persons specified in subsections (1) and (1.3) of this section for direct, nongroup life insurance, health insurance, health maintenance organization, annuity, and supplemental policies or contracts and for certificates under direct group life insurance, health insurance, health maintenance organization, or annuity policies or contracts, and for supplemental contracts to any of these, issued by member insurers pursuant to article 7 and parts 1, 2, and 4 of article 16 of this title 10, except as limited by this article 20. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(b) Except as otherwise provided in subsection (2)(c) of this section, this article 20 does not provide coverage for:

(I) Any portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

(II) Any policy or contract of reinsurance, unless assumption certificates have been issued under the reinsurance policy or contract;

(III) Any portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or other factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns and changes in value:

(A) When averaged over the period of four years prior to the date on which the association became obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average, averaged for that same four-year period, or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

(B) On and after the date on which the association became obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

(IV) Any portion of a policy, contract, plan, or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(A) A multiple employer welfare arrangement, as defined in section 1002 of title 29 of the United States Code;

(B) A minimum premium group insurance plan;

(C) A stop-loss group insurance plan; or

(D) An administrative services only contract;

(V) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, voting rights, or that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract;

(VI) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;

(VII) Any unallocated annuity contract;

(VIII) Any annuity contract or group annuity certificate which is used by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees for the purpose of providing retirement benefits;

(IX) Any policy, contract, certificate, or subscriber agreement issued by a prepaid dental care plan as defined in parts 1 and 5 of article 16 of this title;

(X) Services covered under a policy of sickness and accident insurance as defined in section 10-16-102 (50) when written by a property and casualty insurer as part of an automobile insurance contract;

(XI) Repealed.

(XII) Any member insurer that was insolvent or unable to fulfill its contractual obligations as of July 1, 1991; except that an annuity contract issued or assumed by such a member insurer shall be covered under this article 20 if the member insurer was ordered into liquidation between July 1, 1991, and August 31, 1991;

(XIII) Repealed.

(XIV) Any portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract but such changes have not been credited to the policy or contract, or to the extent the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this article. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this section, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of insolvency, and such interest or changes shall not be subject to forfeiture.

(XV) Repealed.

(XVI) Any policy or contract providing hospital, medical, prescription drug, or other health-care benefits under:

(A) Part C or part D of subchapter XVIII, chapter 7 of title 42, United States Code, or any regulation issued under those parts C or D; or

(B) Subchapter XIX, chapter 7 of title 42, United States Code, or any regulation issued under Subchapter XIX;

(XVII) Any portion of a policy or contract to the extent that the assessment required by this article with respect to the policy or contract are preempted or otherwise not allowed by federal or state law;

(XVIII) Any obligation that does not arise under the expressed written terms of the policy or contract issued by the member insurer to the owner, certificate holder, or enrollee, including:

(A) Claims based on marketing materials, brochures, illustrations, advertisements, or oral statements by agents, brokers, or others used or made in connection with the sale of covered policies and contracts;

(B) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) Misrepresentations of, or regarding, policy or contract benefits;

(D) Extracontractual claims; and

(E) Claims for penalties, interest, or consequential or incidental damages;

(XIX) Any contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by a benefit plan or trustee that is not an affiliate of the member insurer;

(XX) Structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction, as defined in 26 U.S.C. sec. 5891 (c)(3)(A), regardless of whether the transaction occurred before, on, or after the effective date of 26 U.S.C. sec. 5891 (c)(3)(A).

(c) The exclusions from coverage specified in subsection (2)(b)(III) of this section do not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

(3) The benefits for which the association may become liable must not exceed the lesser of:

(a) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b)

(I) With respect to any one life, regardless of the number of policies or contracts with that member insurer:

(A) Three hundred thousand dollars in net life insurance death benefits, and no more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(B) For health insurance benefits or coverage received under health maintenance organization contracts: One hundred thousand dollars for coverages not defined as disability, coverage or services under health benefit plans, or long-term care insurance, including any net cash surrender and net cash withdrawal values; three hundred thousand dollars for disability insurance; three hundred thousand dollars for long-term care insurance; or five hundred thousand dollars for coverage or services under health benefit plans;

(C) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(D) With respect to each payee of a structured settlement annuity, two hundred fifty thousand dollars in present-value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values.

(E) (Deleted by amendment, L. 2013.)

(II) The association is not obligated to cover:

(A) More than three hundred thousand dollars in benefits, in the aggregate, with respect to any one life under subsection (3)(b)(I) of this section; except that, with respect to benefits for coverage or services under health benefit plans under subsection (3)(b)(I)(B) of this section, the aggregate liability of the association must not exceed five hundred thousand dollars with respect to any one life; or

(B) More than five million dollars in benefits with respect to an owner of multiple nongroup policies of life insurance, regardless of whether the policy owner is an individual, firm,

corporation, or other person; whether the persons insured are officers, managers, employees, or other persons; or the number of policies and contracts held by the owner.

(c) The limitations set forth in this subsection (3) are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this subsection (3) may be met by the use of assets attributable to covered policies or reimbursed to the association under its subrogation and assignment rights.

(3.5) For purposes of this article 20, benefits provided by a long-term care rider to a life insurance policy or annuity are considered the same type of benefits as the benefits provided by the underlying life insurance policy or annuity contract to which the rider relates.

(4) In performing its obligations to provide coverage under section 10-20-108, the association is not required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the impaired or insolvent insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

History

Source:L. 91: Entire article added, p. 1258, § 1, effective July 1.**L. 92:**(2)(a), (2)(b)(IX), and (2)(b)(X) amended, p. 1725, § 11, effective July 1.**L. 94:**(2)(b)(XII) amended, p. 614, § 1, effective April 13.**L. 2000:**IP(1)(a), (2)(b)(III), (2)(b)(VII), (2)(b)(XIII), (2)(b)(XIV), and (3)(b) amended and (1.3), (1.5), and (1.7) added, p. 1018, § 2, effective July 1.**L. 2010:**(3)(b)(I)(C), (3)(b)(I)(D), and (3)(b)(II) amended and (3)(b)(I)(E) added, *(SB 10-049), ch. 15, p. 75, § 1*, effective March 5.**L. 2013:**(2)(a), IP(2)(b), (2)(b)(I), (2)(b)(II), (2)(b)(III), IP(2)(b)(IV), (2)(b)(IV)(A), (2)(b)(V), (2)(b)(XIV), (3), and (4) amended, (2)(b)(XI), (2)(b)(XIII), and (2)(b)(XV) repealed, and (2)(b)(XVI) to (2)(b)(XIX) added *(SB 13-032), ch. 34, p. 83, § 2*, effective March 15; (2)(b)(X) amended, *(HB 13-1266), ch. 217, p. 990, § 56*, effective May 13.**L. 2023:**IP(1), IP(1)(a), (1)(a)(II)(A), (1)(a)(II)(B), (1)(b), (1.5), (1.7), (2)(a), IP(2)(b), (2)(b)(XII), (2)(b)(XVI), IP(2)(b)(XVIII), (2)(b)(XVIII)(B), (2)(b)(XVIII)(C), IP(3), (3)(a), IP(3)(b)(I), (3)(b)(I)(B), (3)(b)(II)(A), and (4) amended and (2)(b)(XX), (2)(c), and (3.5) added, *(HB 23-1303), ch. 195, p. 981, § 5*, effective May 15.

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C.R.S. 10-20-105

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

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10-20-105. Construction.

This article shall be construed to effect the purpose set forth in section 10-20-102, which shall constitute an aid and guide to interpretation.

History

Source:L. 91: Entire article added, p. 1261, § 1, effective July 1.

End of Document

C.R.S. 10-20-106

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

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10-20-106. Creation of the association.

(1) There is hereby created a private nonprofit legal entity to be known as the life and health insurance protection association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance or health maintenance organization business in this state. The association shall perform its functions pursuant to the plan of operation specified in section 10-20-110 and shall exercise its powers through the board of directors provided in section 10-20-107. For purposes of administration and assessment, the association shall maintain three accounts:

(a) The life insurance account;

(b) The health insurance account; and

(c) The annuity account.

(2) The association is under the supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public consistent with the provisions of the insurance laws of Colorado upon majority vote of the board.

History

Source:L. 91: Entire article added, p. 1261, § 1, effective July 1.**L. 2013:**(2) amended, *(SB 13-032), ch. 34, p. 87, § 3*, effective March 15.**L. 2023:**IP(1) amended, *(HB 23-1303), ch. 195, p. 984, § 6*, effective May 15.

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C.R.S. 10-20-107

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

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10-20-107. Board of directors.

(1) The board of directors of the association consists of no fewer than seven nor more than eleven member insurers serving terms as established in the plan of operation. Member insurers shall select members of the board, subject to the approval of the commissioner. If a vacancy occurs, the remaining board members shall fill the vacancy for the remaining period of the term by a majority vote, subject to the approval of the commissioner. To select the first board and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. At the organizational meeting, each member insurer is entitled to one vote in person or by proxy. If the board is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.

(2) In approving selections or in appointing members to the board, the commissioner shall ensure that all member insurers are fairly represented between member insurers that write primarily life insurance or annuity contracts and member insurers that write primarily health benefit plans. The commissioner shall also consider whether member insurers with experience in providing large group health benefit plans to employers whose employees are subject to a collective bargaining agreement are represented on the board.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board, but members of the board shall not otherwise be compensated by the association for their services.

History

Source:L. 91: Entire article added, p. 1262, § 1, effective July 1.**L. 2023:**(1) and (2) amended, *(HB 23-1303), ch. 195, p. 984, § 7*, effective May 15.

End of Document

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

10-20-108. Powers and duties of the association.

(1) If a member insurer is an impaired insurer, the association may, in its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(a) Guarantee, assume, reissue, or reinsure or cause to be guaranteed, assumed, reissued, or reinsured any or all of the policies or contracts of the impaired insurer; or

(b) Provide such moneys, pledges, loans, notes, guarantees, or other means as proper to effectuate paragraph (a) of this subsection (1) and assure payment of the contractual obligations of the impaired insurer pending action under said paragraph (a).

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a) Guarantee, assume, reissue, or reinsure or cause to be guaranteed, assumed, reissued, or reinsured the covered policies or contracts of the insolvent insurer and provide such money, pledges, notes, guarantees, or other means as are reasonably necessary to discharge those duties; or

(b) Assure payment of the contractual obligations of the insolvent insurer to the residents and provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge those duties; or

(c) Provide benefits and coverages in accordance with the following provisions:

(I) With respect only to life insurance, health insurance, health benefit plans, and annuities, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

(A) With respect to group policies and contracts, not later than the earlier of the next renewal date under the policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to the policies or contracts;

(B) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than thirty days, after the date on which the association becomes obligated with respect to the policies or contracts.

(II) Make diligent efforts to provide to all known insureds, enrollees, or annuitants for nongroup policies and contracts, or to group policy or contract owners with respect to group policies and contracts, thirty days' notice of the termination under subsection (2)(c)(I) of this section of the benefits provided.

(III) With respect to nongroup life insurance, health insurance, health benefit plans, and annuities covered by the association, make available to each known insured, enrollee, or annuitant, or to the owner if other than the insured, enrollee, or annuitant, and with respect to an individual formerly insured or enrolled or formerly an annuitant under a group policy or contract who is not eligible for replacement group coverage, substitute coverage on an individual basis in accordance with

subsection (2)(c)(IV) of this section, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right to unilaterally make changes in any provisions of the policy, contract, or annuity or had a right only to make changes in premium by class.

(IV)

(A) In providing the substitute coverage required under subsection (2)(c)(III) of this section, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates approved by the commissioner.

(B) The association shall offer alternative or reissued policies or contracts without requiring evidence of insurability, and the policies or contracts must not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.

(C) The association may reinsure any alternative or reissued policy or contract.

(V)

(A) Alternative policies or contracts adopted by the association are subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(B) Alternative policies or contracts must contain at least the minimum statutory provisions required in this state and provide benefits reasonably related to the premium charged. The association shall set the premium in accordance with a table of rates that the association adopts. The premium must reflect the amount of insurance or coverage to be provided and the age and class of risk of each insured but must not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

(C) Any alternative policy or contract issued by the association must provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.

(VI) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the association shall set an actuarially justified premium in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to approval by the commissioner.

(VII) The obligations of the association, with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract, cease on the date the coverage, policy, or contract is replaced by another similar policy or contract by the policy owner, insured, enrollee, or association.

(VIII) When proceeding under this subsection (2)(c), with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with *section 10-20-104* (2)(b)(III).

(3) and (4) Repealed.

(5) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the obligations of the association under the policy, contract, or coverage under this article 20 with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with this article 20.

(6) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(6.5) The protection provided by this article does not apply when guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(7) In carrying out its duties under subsection (2) of this section, the association may, subject to approval by a court of competent jurisdiction:

(a) Impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the duties of the association under this article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest;

(b) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts out of the assets of the impaired or insolvent insurer, the association may defer its payment of cash values, policy loans, or other rights of the association for the period of the moratorium or moratorium charge by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(8) If the association fails to act within a reasonable period of time as provided in subsection (2) of this section, the commissioner shall have the powers and duties of the association under this article with respect to insolvent insurers.

(9) There shall be no liability on the part of, and no cause of action shall arise against, the association, or any transferee from the association in connection with the transfer by reinsurance or otherwise of all or any part of an impaired or insolvent insurer's business by reason of any action taken or any failure to take any action by the impaired or insolvent insurer at any time.

(10) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(11) The association has standing to appear or intervene before any court or agency in this state that has jurisdiction over a member insurer for which the association is or may become obligated under this article 20, or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. The association's standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the member insurer and the determination of the policies or contracts and contractual obligations. The association also has the right to appear or intervene before a court or agency in another state with jurisdiction over a member insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(12)

(a) Any person receiving benefits under this article 20 is deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this article 20, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or the provision of substitute or alternative policies, contracts, or coverage. The association may require any payee, policy or contract owner, beneficiary, insured, enrollee, or annuitant to assign the person's rights under, and causes of action against any person for

losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association as a condition precedent to the receipt of any right or benefits conferred by this article 20 upon the person.

(b) The subrogation rights of the association under this subsection (12) have the same priority against the assets of the impaired or insolvent insurer as the rights possessed by the person entitled to receive benefits under this article 20.

(c) In addition to subsections (12)(a) and (12)(b) of this section, the association has all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer, owner, beneficiary, enrollee, or payee of a policy or contract.

(d) If any provision of subsection (12)(a), (12)(b), or (12)(c) of this section is invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations is reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts or portions of the policies or contracts covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in subsections (12)(a) to (12)(d) of this section, the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or portions of policies or contracts, covered by the association.

(13) The association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this article;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments pursuant to *section 10-20-109* and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this article 20, and any notes or other evidence of indebtedness of the association not in default are legal investments for domestic member insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this article;

(e) Take such legal action as necessary to avoid payment of improper claims or recover payment of improper claims;

(f) Exercise, for the purposes of this article 20 and to the extent approved by the commissioner, the powers of a domestic life insurer, health insurer, or health maintenance organization, but the association shall not issue policies or contracts other than those issued to perform its obligations under this article 20;

(g) Negotiate and contract with any liquidator or ancillary receiver to carry out the powers and duties of the association;

(g.5) Request information from persons seeking coverage from the association in order to aid the association in determining its obligations under this article with respect to the person; and a person receiving such request shall promptly comply;

(g.7) Take other necessary or appropriate action to exercise its powers and discharge its duties and obligations under this article;

(h) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, elect to succeed to the rights of an insolvent insurer arising after the date of the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making this election, the association shall pay unpaid premiums due with

respect to policies covered by the association for coverage relating to periods both before and after the date of the order of liquidation.

(i) File for an actuarially justified rate or premium increase for any policy or contract that it guarantees, assumes, reinsures, reissues, or otherwise provides coverage under this section in accordance with the terms and conditions of the policy or contract and in accordance with other applicable provisions of state law.

(14) The association may join an organization of one or more other state associations of similar purposes to further the purposes and to administer the powers and duties of the association.

(15) Every insured or claimant seeking the protection of this article shall cooperate with the association to the same extent the person or entity would have been required to cooperate with the impaired or insolvent insurer. The association has no cause of action against the insured of the impaired or insolvent insurer for any sums the association has paid out except those causes of action the impaired or insolvent insurer would have had if the sums had been paid by the impaired or insolvent insurer. If an impaired or insolvent insurer operates on a plan with assessment liability, payments of claims by the association do not reduce the liability of the insured to the receiver, liquidator, rehabilitator, conservator, or statutory successor for unpaid assessments.

(16) The receiver, liquidator, rehabilitator, conservator, or statutory successor of an impaired or insolvent insurer is bound by settlements of covered claims by the association or a similar organization in another state. The association has a claim against the estate of the impaired or insolvent insurer to the extent of claims and expenses paid by the association in connection with the duties of the association as to the impaired or insolvent insurer. The court having jurisdiction shall grant these settled claims in the priority to which the claimant would have been entitled in the absence of this article against the assets of the impaired or insolvent insurer. The expenses, including legal fees of the association or similar organization in handling claims, shall be given the same priority as the expenses of the liquidator, rehabilitator, or conservator.

(17) The association shall periodically file with the liquidator, rehabilitator, or conservator of the impaired or insolvent insurer statements of the covered claims and associated expenses paid by the association and estimates of anticipated claims against the association. This periodic filing preserves the rights of the association for claims against the assets of the impaired or insolvent insurer.

(18) The association shall investigate claims brought against it and adjust, compromise, settle, and pay covered claims to the extent of the obligation of the association and deny all other claims.

(19) A person who has a claim against a member insurer pursuant to a provision of a policy or contract, other than a policy or contract of an impaired or insolvent insurer, that also is a contractual obligation under this article 20, must first exhaust the person’s right under that policy or contract. The amount of an approved claim under this article 20 must be reduced by the policy or contract limits of, or amount paid under, that policy or contract, whichever amount is greater. If a claimant exhausts all rights under a policy or contract, other than a policy or contract of an impaired or insolvent insurer, the member insurer issuing that policy or contract is not entitled to sue or continue a suit against the insured of the impaired or insolvent insurer to recover an amount paid to the claimant under the policy or contract; except that a person having a contractual obligation, as defined by this article 20, under a life insurance policy or an annuity contract issued by an impaired or insolvent insurer is not required to exhaust other coverage for that claim, and the amount of an approved claim under a life insurance policy or annuity contract issued by an impaired or insolvent insurer may not be reduced because of that duplicate coverage.

(20) Where the association has arranged or offered to provide the benefits of this article to a covered person under a plan or arrangement that fulfills the association’s obligations under this article, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(21) Venue in a suit against the association arising under this article shall be in the city and county of Denver. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this article.

(22) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under this section, the association may issue substitute coverage at actuarially justified rates for a policy or contract that provides for the calculation of returns or changes in value or benefits by the use of an interest rate, crediting rate, or similar factor determined by use of an index or other external reference, by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

(b) There is no requirement for the evidence of insurability, a waiting period, or any other exclusion that would not have applied under the replaced policy or contact;

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

(23) The board has discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this article in an economical and efficient manner.

(24) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsection (1) or (2) of this section, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor, determined by use of an index or other external reference stated in the policy or contract, employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

History

Source:L. 91: Entire article added, p. 1262, § 1, effective July 1.**L. 94:**IP(3)(a) and (4) amended, p. 1650, § 93, effective May 31.**L. 2000:**(10), (11), (12)(a), and (12)(c) amended and (13)(g.5), (13)(g.7), (20), (21), and (22) added, p. 1020, §§ 3, 4, effective July 1.**L. 2002:**(13)(h) amended, p. 122, § 1, effective March 26.**L. 2013:**(1), (2), IP(7), (7)(b), (8), (9), (10), (12)(b), (12)(c), (13)(e), (15), (16), (17), and (19) amended, (3) and (4) repealed, and (6.5), (12)(d), (12)(e), (23), and (24) added,*(SB 13-032), ch. 34, p. 87, § 4*, effective March 15.**L. 2023:**(1)(a), (2)(a), (2)(c), (5), (6), (11), (12), (13)(c), (13)(f), (19), IP(22), and IP(24) amended and (13)(i) added,*(HB 23-1303), ch. 195, p. 984, § 8*, effective May 15.

End of Document

C.R.S. 10-20-109

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-109. Assessments.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess each member insurer separately for each account at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at the rate set forth in 28 U.S.C. sec. 1961 on and after the due date.

(2) The board shall impose two assessments, as follows:

(a) Class A assessments must be authorized and called for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of section 10-20-115; except that the board shall not impose a class A assessment against a member insurer that has not received premiums for a covered policy in the calendar year immediately preceding the calendar year in which the assessment is imposed. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments must be authorized and called to the extent necessary to carry out the powers and duties of the association under section 10-20-108 with regard to an impaired or insolvent insurer.

(3)

(a) The amount of any class A assessment must be determined by the board and may be authorized and called on a non-pro rata basis. The amount of any class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion to be fair and reasonable under the circumstances.

(b)

(I) The board shall determine class B assessments against member insurers for each account based on the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, bear to the premiums received on business in this state for those calendar years by all assessed member insurers.

(II) Of the amount of class B assessments for long-term care insurance written by the impaired or insolvent insurer, the board shall allocate:

(A) Fifty percent to the health insurance account; except that a member insurer that is a nonprofit health maintenance organization that provides a majority of covered professional services through physicians it employs or through a single contracted medical group shall be assessed as if the board allocated only twenty-five percent to the health insurance account; and

(B) Fifty percent, on a pro rata basis, to the life insurance account and the annuity account; except that, on a pro rata basis, the life insurance account and the annuity account shall cover the shortfall from the health insurance account that results from the lower assessment rate described in subsection (3)(b)(II)(A) of this section on a member insurer that is a nonprofit health maintenance organization that provides a majority of covered professional services through physicians it employs or through a single contracted medical group.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer must not be authorized or called until necessary to implement the purposes of this article. Classification of assessments under subsection (2) of this section and computation of assessments under this subsection (3) shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(5)

(a) Subject to subsection (5)(b) of this section, the total of all assessments authorized by the association with respect to a member insurer for each account must not exceed, in any one calendar year, two percent of the average premiums received by the member insurer in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the member insurer became impaired or insolvent.

(b) If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subsection (5)(a) of this section is equal and limited to the highest of the three-year average annual premiums for the applicable account as calculated under this section.

(c) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any of the accounts an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(d) The board shall provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(6) The board shall, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out, during the coming year, the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. The board shall retain a reasonable amount in each account to provide funds for the continuing expenses of the association and for future losses.

(7)

(a) A member insurer, in determining its premium rates and policyholder dividends for any kind of insurance or health maintenance organization business within the scope of this article 20, may consider the amount reasonably necessary to meet its assessment obligations under this article 20.

(b) A member insurer subject to assessments pursuant to subsection (2) of this section shall not cut employment, reduce employee pay or hours, or reduce employment benefits as a result of the assessments levied pursuant to subsection (2) of this section.

(8) The association shall issue to each member insurer paying an assessment for the life and annuity accounts under this article 20, other than a class A assessment, a certificate of contribution from the association, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. The member insurer may show the certificate of contribution in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve; but the member insurer, at its option, has the right in any event to show the certificate of contribution as an admitted asset at percentages of the original face amount of the assessment for calendar years as follows:

(a) One hundred percent for the first year after issuance; and

(b) One hundred percent less any amount already taken as an offset against premium tax liability pursuant to section 10-20-113 for the second and subsequent years after issuance.

(9) Any member insurer whose certificate of authority or license has been terminated for any reason whatsoever is liable for any assessment based on insolvencies arising prior to termination of a member insurer's certificate of authority or license.

(10)

(a) A member insurer that intends to protest all or part of an assessment shall pay, when due, the full amount of the assessment in the notice provided by the association. The payment must be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payments must be accompanied by a statement in writing that the payment is made under protest and a brief statement of the grounds for the protest.

(b) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty days after a final decision, the association shall notify the protesting member insurer in writing of the final decision. Within sixty days after receiving notice of the final decision, the protesting member insurer may appeal the final decision to the commissioner.

(d) In alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests directly to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the association must return the amount paid in error or excess to the member insurer. Interest on a refund due to a protesting member insurer must be paid at the rate actually earned by the association.

(11) The association may request information of member insurers in order to aid in the exercise of its power under this section. Member insurers shall promptly reply to any request for information from the association.

History

Source:L. 91: Entire article added, p. 1269, § 1, effective July 1.**L. 2000:**(8) amended, p. 1022, § 5, effective July 1.**L. 2013:**(2), (3), (5), and (10) amended and (11) added, *(SB 13-032), ch. 34, p. 94, § 5*, effective March 15.**L. 2023:**IP(2), (2)(a), (3)(b), (5)(a), (5)(b), (6), (7), IP(8), and (9) amended, *(HB 23-1303), ch. 195, p. 989, § 9*, effective May 15.

End of Document

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

10-20-110. Plan of operation - rules.

(1)

(a) The association shall maintain a plan of operation to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall be submitted to the commissioner and be effective upon the commissioner's written approval or after thirty days if said commissioner has not disapproved.

(b) If the association fails to submit a suitable plan of operation or suitable amendments to the plan within sixty days after May 15, 2023, the commissioner shall, after notice and hearing, adopt and promulgate reasonable rules as necessary or advisable to effectuate this article 20. The rules continue in effect until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation must, in addition to any other provisions specified in this article:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board pursuant to section 10-20-107;

(c) Establish regular places and times for meetings including telephone conference calls of the board;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board;

(e) Establish the procedures whereby selections for the board will be made and submitted to the commissioner;

(f) Establish any additional procedures for assessments under section 10-20-109;

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association;

(h) Establish procedures whereby a director may be removed for cause, including a director or member insurer that becomes an impaired or insolvent insurer;

(i) Require the board of directors to establish a policy and procedures to address conflicts of interest.

(4) The plan of operation may provide that any or all powers and duties of the association, except those established pursuant to sections 10-20-108 (13)(c) and 10-20-109, are delegated to a corporation, association, or other organization that performs, or will perform, functions similar to those of the association established pursuant to this article 20 or its equivalent in two or more states. The association shall reimburse a corporation, association, or organization to which the association has delegated its powers and duties for any payments made on behalf of the association and shall pay the corporation, association, or organization for its performance of any association function. A delegation pursuant to this subsection (4)

takes effect only with the approval of both the board and the commissioner, and the association may delegate its powers and duties only to a corporation, association, or organization that extends protection not substantially less favorable and effective than the protection provided by this article 20.

(5) Repealed.

History

Source:L. 91: Entire article added, p. 1272, § 1, effective July 1.**L. 2013:**IP(3) amended, (3)(h) and (3)(i) added, and (5) repealed, *(SB 13-032), ch. 34, p. 96, § 6*, effective March 15.**L. 2023:**(1)(b) and (4) amended, *(HB 23-1303), ch. 195, p. 991, § 10*, effective May 15.

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C.R.S. 10-20-111

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-111. Powers and duties of the commissioner.

(1) In addition to any other powers and duties specified in this article 20, the commissioner shall:

(a) Upon request of the board, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

(b) Notify the board of the existence of an impaired or insolvent insurer not later than three days after a determination of impairment or insolvency is made by the commissioner, irrespective of limitations imposed upon the commissioner in section 10-3-401;

(c) In any liquidation proceeding involving a domestic member insurer, be appointed as the liquidator.

(2) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority or license to transact insurance or the business of a health maintenance organization in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture must not exceed five percent of the unpaid assessment per month, but a forfeiture must not be less than one hundred dollars per month.

(3) The conservator, rehabilitator, or liquidator of any impaired or insolvent insurer shall notify all interested persons of the effect of this article.

History

Source:L. 91: Entire article added, p. 1274, § 1, effective July 1.**L. 2013:**(1)(b) and (3) amended, *(SB 13-032), ch. 34, p. 97, § 7*, effective March 15.**L. 2023:**IP(1), (1)(c), and (2) amended, *(HB 23-1303), ch. 195, p. 991, § 11*, effective May 15.

End of Document

C.R.S. 10-20-112

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-112. Prevention of insolvencies.

(1) To aid in the detection and prevention of member insurer insolvencies, it is the duty of the commissioner:

(a) To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when action is taken in any of the following matters against a member insurer:

(I) Revocation of license;

(II) Suspension of license; or

(III) Issuance of a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of owners, certificate holders, enrollees, or creditors. The commissioner shall mail the notice to all commissioners within thirty days following the action taken or the date on which the action occurs.

(b) To report to the board when the commissioner has taken any of the actions set forth in paragraph (a) of this subsection (1) or has received a report from any other commissioner indicating that such action has been taken in another state. Such report to the board shall contain all significant details of the action taken or the report received from another commissioner.

(c) To report to the board when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the member insurer may be an impaired or insolvent insurer;

(d) To furnish to the board the NAIC insurance regulatory information system ratios and listings of companies not included in the ratios developed by the NAIC, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein shall be kept confidential by the board until such time as made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance or health maintenance organization business in this state.

(3) Upon the commissioner's request, the board shall report and make recommendations to the commissioner upon any matter germane to the solvency or liquidation of any member insurer or germane to the solvency of any company seeking to do insurance or health maintenance organization business in this state. The reports and recommendations are not public documents.

(4) The board of directors may, upon a majority vote, notify the commissioner of any information indicating that a member insurer may be impaired or insolvent.

(5) Repealed.

(6) The board may make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

(7) Repealed.

History

Source:L. 91: Entire article added, p. 1274, § 1, effective July 1.**L. 2000:**(3), (4), (5), (6), and (7) amended, p. 1023, § 6, effective July 1.**L. 2013:**(1)(c) and (4) amended and (5) and (7) repealed, *(SB 13-032), ch. 34, p. 97, § 8*, effective March 15.**L. 2023:**IP(1), (1)(a)(III), (1)(c), (2), (3), and (6) amended, *(HB 23-1303), ch. 195, p. 992, § 12*, effective May 15.

End of Document

C.R.S. 10-20-113

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-113. Credits for assessments paid - tax offsets.

(1)

(a) A member insurer may offset against its premium tax liability to this state that amount of its class B assessment described in section 10-20-109 that was assessed for the association's life and annuity accounts pursuant to section 10-20-106 to the extent of twenty percent of the amount of such assessment for each of the first, second, third, fourth, and fifth calendar years following the year in which such assessment was paid.

(b) To the extent the offsets specified in paragraph (a) of this subsection (1) exceed the member insurer's premium tax liability, they may be carried forward to offset premium tax liabilities in future years. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(c) In no event shall the total amount of all such offsets for all member insurers exceed four million dollars in any year. The association shall prorate the amount of such offset among all member insurers if the total amount of offset would otherwise exceed four million dollars in any such year and shall notify each insurer of the maximum amount of offset allowable for that year and the amount of the excess offset, if any, that may be carried forward to future years.

(d)

(I) Each member insurer writing health insurance or health maintenance organization policies or contracts may recoup over a reasonable length of time a sum reasonably calculated to recoup the assessments paid by the member insurer under this article 20 by imposing a surcharge on premiums charged for health insurance or health maintenance organization policies or contracts to which this article 20 applies. Amounts recouped are not premiums for any other purpose, including the computation of gross premium tax or an agent's commission.

(II) A member insurer that imposes a surcharge under subsection (1)(d)(I) of this section shall include the amount of the surcharge as part of the member insurer's rate filing pursuant to section 10-16-107 (1). The member insurer must show the surcharge in the rate filing as a separate component of the rate and shall include supporting documentation.

(III) A member insurer that collects surcharges in excess of assessments paid pursuant to this article 20 for an insolvent insurer shall remit the excess to the association as an additional assessment within one hundred twenty days after the end of the collection period as determined by the association. The association shall apply the excess amount to reduce future assessments for that member insurer in the appropriate category.

(IV) (Deleted by amendment, L. 2023.)

(2) Any sums which are acquired by refund pursuant to section 10-20-109 (6) from the association by member insurers, and which have theretofore been offset against premium taxes as provided in subsection (1) of this section, shall be paid by such insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such payments have been made.

History

Source:L. 91: Entire article added, p. 1276, § 1, effective July 1.**L. 92:**(1)(d)(II) amended, p. 1726, § 12, effective July 1.**L. 2000:**(1)(a) and (1)(c) amended, p. 1023, § 7, effective July 1.**L. 2023:**(1)(d) amended, *(HB 23-1303), ch. 195, p. 992, § 13*, effective May 15.

End of Document

C.R.S. 10-20-114

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-114. Miscellaneous provisions - definition.

(1) Nothing in this article 20 reduces the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) The association must keep records of all meetings of the board to discuss the activities of the association in carrying out its powers and duties pursuant to section 10-20-108. Records of the meetings may be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the member insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection (2) limits the duty of the association to render a report of its activities under section 10-20-115.

(3) For the purpose of carrying out its obligations under this article 20, the association is deemed a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies and covered contracts, reduced by any amounts to which the association is entitled as assignee or subrogee pursuant to section 10-20-108 (12). Assets of the impaired or insolvent insurer attributable to covered policies and covered contracts shall be used to continue all covered policies and covered contracts and pay all contractual obligations of the impaired or insolvent insurer as required by this article 20. “Assets of the impaired or insolvent insurer attributable to covered policies and covered contracts”, as used in this subsection (3), means that proportion of the assets that the reserves that should have been established for the policies or contracts bear to the reserves that should have been established for all policies or contracts written by the impaired or insolvent insurer.

(3.5) As a creditor of an impaired or insolvent insurer as established in this section and consistent with section 10-3-533, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets from time to time as the assets become available to reimburse the association, as a credit against contractual obligations under this article 20. If the liquidator has not made an application to the receivership court for approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency within one hundred twenty days after a final determination of insolvency of a member insurer by the receivership court, the association may apply to the receivership court for approval of its own proposal to disburse these assets.

(4)

(a) Prior to the termination of any rehabilitation, conservation, or liquidation proceeding, the court may take into consideration the contributions of the respective parties, including the association, shareholders, owners, certificate holders, or enrollees of the impaired or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In making a determination under this subsection (4)(a), the court shall consider the welfare of the owners, certificate holders, or enrollees of the continuing or successor member insurer.

(b) A distribution shall not be made to stockholders, if any, of an impaired or insolvent insurer until the total amount of valid claims of the association for reimbursement, including interest, of funds expended in carrying out its powers and duties pursuant to section 10-20-108 with respect to the impaired or insolvent insurer have been fully recovered by the association.

(5)

(a) If an order for rehabilitation or liquidation of a member insurer domiciled in this state has been entered, the receiver appointed under the order has a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation, subject to the limitations of subsections (5)(b) to (5)(d) of this section.

(b) A distribution described in subsection (5)(a) of this section is not recoverable if the member insurer shows that the distribution, when it was paid, was lawful and reasonable and that the member insurer did not know, and could not reasonably have known, that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid is liable up to the amount of distributions the person received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared is liable up to the amount of the distributions the person would have received if the distributions had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this subsection (5) is the amount needed, in excess of all other available assets of the impaired or insolvent insurer, to pay the contractual obligations of the impaired or insolvent insurer.

(e) If any person liable pursuant to subsection (5)(c) of this section is insolvent, all of its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(6) Nothing in this article 20 imposes any liability or responsibility on the state of Colorado for the obligations of the life and health insurance protection association or the unpaid claims of impaired or insolvent insurers.

History

Source:L. 91: Entire article added, p. 1278, § 1, effective July 1.**L. 2013:**(1), (2), (3), (4), (5)(a), and (5)(d) amended and (3.5) added, *(SB 13-032), ch. 34, p. 98, § 9*, effective March 15.**L. 2023:**Entire section amended, *(HB 23-1303), ch. 195, p. 993, § 14*, effective May 15.

End of Document

C.R.S. 10-20-115

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-115. Examination of the association - annual report.

The association shall be subject to examination and regulation by the commissioner. The board shall submit to the commissioner each year, not later than one hundred twenty days after the close of the fiscal year of the association, a financial report in a form approved by the commissioner, and a report of the activities of the board during the preceding fiscal year.

History

Source:L. 91: Entire article added, p. 1280, § 1, effective July 1.

End of Document

C.R.S. 10-20-116

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-116. Tax exemptions.

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real and personal property.

History

Source:L. 91: Entire article added, p. 1280, § 1, effective July 1.

End of Document

C.R.S. 10-20-117

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-117. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, its agents, or its employees, the association, its agents, or its employees, members of the board or the commissioner or his representatives for any action or omission by them in the performance of their powers and duties pursuant to this article. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

History

Source:L. 91: Entire article added, p. 1280, § 1, effective July 1.

End of Document

C.R.S. 10-20-118

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-118. Stay of proceedings - reopening default judgments.

All proceedings in which the impaired or insolvent insurer is a party in any court in this state shall be stayed for one hundred eighty days after the date an order of conservation, rehabilitation, or liquidation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that issued the judgment and shall be permitted to defend against such suit on the merits.

History

Source:L. 91: Entire article added, p. 1280, § 1, effective July 1.**L. 2013:**Entire section amended, *(SB 13-032), ch. 34, p. 99, § 10*, effective March 15.

End of Document

C.R.S. 10-20-119

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-119. Prohibited advertisement of association article in insurance sales - notice to owners, certificate holders, and enrollees.

(1) A person, including a member insurer and any agent or affiliate of a member insurer, shall not make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, that uses the existence of the life and health insurance protection association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this article 20. However, this section does not apply to the association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

(2) The association shall prepare a summary document, in compliance with subsection (3) of this section, describing the general purposes and current limitations of this article 20. The association shall submit the summary document to the commissioner for approval. Sixty days after receiving approval from the commissioner, each member insurer, when delivering a policy or contract as described in section 10-20-104 (2)(a) to an owner, a certificate holder, or an enrollee, shall deliver the summary document concurrently with or before delivering the policy or contract unless subsection (4) of this section applies. The member insurer shall also make the summary document available upon request by an owner, a certificate holder, or an enrollee. The distribution, delivery, or contents or interpretation of the summary document does not mean that either the policy or the contract or the owner, certificate holder, or enrollee will be covered in the event of impairment or insolvency of a member insurer. The association shall revise the summary document as necessary based on amendments to this article 20 or as other circumstances may require. Failure to receive this summary document does not give an owner, a certificate holder, an insured, or an enrollee any rights other than those stated in this article 20.

(3) The summary document prepared pursuant to subsection (2) of this section must contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer must:

(a) State the name and address of the association and the division of insurance;

(b) Prominently warn the owner, certificate holder, or enrollee that the association may not cover the policy or contract or, if coverage is available, the policy or contract may be subject to substantial limitations and exclusions and is conditioned on the continued residence in the state by the owner, insured, certificate holder, or enrollee;

(c) State that the member insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage;

(d) Emphasize that the owner, certificate holder, or enrollee should not rely on coverage by the association when selecting a member insurer; and

(e) Provide other information as directed by the commissioner.

(4) A member insurer or agent of a member insurer shall not deliver a policy or contract that is described in section 10-20-104 (2)(a) but excluded under section 10-20-104 (2)(b)(I) from coverage under this article 20 unless the member insurer or agent, before or at the time of delivery, gives the owner, certificate holder, or enrollee a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the association. The commissioner shall specify the form and content of the notice.

History

Source:L. 91: Entire article added, p. 1280, § 1, effective July 1.**L. 2023:**Entire section amended, *(HB 23-1303), ch. 195, p. 995, § 15*, effective May 15.

End of Document

C.R.S. 10-20-120

Statutes current and final through all legislation from the 2023 Regular and First Extraordinary Sessions.

Colorado Revised Statutes Annotated > Title 10. Insurance (§§ 10-1-101 — 10-23-110) > Life and Health Insurance Protection (Art. 20) > Article 20. Life and Health Insurance Protection Association (§§ 10-20-101 — 10-20-120)

10-20-120. Prospective application.

This article 20, as amended, does not apply to any member insurer that is declared insolvent on or before May 15, 2023.

History

Source:L. 91: Entire article added, p. 1282, § 1, effective July 1.**L. 2023:**Entire section amended, *(HB 23-1303), ch. 195, p. 996, § 16*, effective May 15.

End of Document