COLORADO DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

CORPORATE ISSUES

3 CCR 702-2

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

Regulation 2-1-1 FINANCIAL RESPONSIBILITY REQUIREMENTS FOR HEALTH CARE INSTITUTIONS

Section 1 Authority

This regulation is promulgated under the authority of § 10-1-109, C.R.S.

Section 2 Background and Purpose

A. Effective July 1, 1988 the Health Care Availability Act, § 13-64-101 through 503, C.R.S., was enacted for the purpose, in part, of assuring continued availability of adequate health care services for the people of Colorado by containing the significantly increasing costs of malpractice insurance for health care institutions and licensed medical care professionals, and that such is rationally related to a legitimate state interest.

B. Health care institutions are required to establish financial responsibility as set forth in §13-64-301 (1)(b), (c), (d) & (e), C.R.S. Sections 13-64-301(1)(b), (c), (d) & (e), C.R.S. provide that each health care institution, in order to maintain its condition of active licensure, maintain one of the following forms of coverage:

(1) commercial professional liability insurance coverage in an amount established by statute;

(2) a surety bond in a form acceptable to the Commissioner;

(3) cash or cash equivalents on deposit with the Commissioner; or

(4) any other security, acceptable to the Commissioner, which may include a plan of self-insurance.

C. Regulation 2-1-1 was originally promulgated effective September 1, 1989. The purpose of amending this regulation is to clarify for the applicant the documents and information which are acceptable to the Commissioner to establish financial responsibility in compliance with § 13-64-301(1)(b), (c), (d) and (e), C.R.S.

Section 3 Definitions

A. "Applicant" as used in this regulation means the health care institution or a corporation or other entity which is assuming the risks of the underlying health care institution or institutions.

B. "Commissioner" as used herein means the Colorado Commissioner of Insurance.

C. "Holding company system" as used in this regulation means a structure whereby a parent company directly or indirectly owns or controls the health care institution.

Section 4 Requirements For Establishing Financial Responsibility

A. Each filing must be submitted by the applicant to the Corporate Affairs Section of the Division of Insurance for review at least sixty (60) days prior to the expiration date of the prior qualifying financial responsibility arrangement.

B. The submission shall include a detailed explanation of the overall plan of operation, list of each health care institution included in the plan, each health care institution location, method of compliance, whether coverage is to be on an occurrence or claims-made basis, administrative procedures, including copies of any contracts and subcontracts related to the plan of financial responsibility.

C. Where the coverage is being offered on a claims-made basis, the coverage must meet the requirements of § 10-4-419, C.R.S., where applicable.

D. Applicants maintain Surety bonds filed pursuant to § 13-64-301(1)(c), C.R.S. must file a copy of the executed bond with the Division which includes the following information:

1. The name of the licensed insurance company, which is authorized to operate in the State of Colorado, issuing the bond;

2. The amount of the bond;

3. The type of bond;

4. A provision that the bond is issued in favor of third party claimants against the applicant for payments of medical malpractice settlements, arbitration awards, or judgments;

5. A provision for 90 day notice to the Commissioner of Insurance in the event of cancellation or nonrenewal; and

6. Supplemental evidence satisfactory to the Commissioner that the amount of the bond is sufficient to fund the applicant's approval year obligation of $500,000 per incident/ $3,000,000 aggregate per year per institution plus whatever remaining liability there may be for prior year's coverage.

E. Applicants depositing cash or cash equivalents pursuant to § 13-64-301(1)(d), C.R.S. must

comply with the following:

1. The form of cash equivalents deposited by any applicant must be approved by the Commissioner.

2. The funds shall be held under joint control with the Commissioner pursuant to § 10-3-210, C.R.S.

3. The market value shall be sufficient to fund the applicant's approval year obligation of $500,000 per incident/$3,000,000 aggregate per year per institution plus whatever remaining liability there may be for prior year's coverage.

F. To determine the adequacy of financial ability for those applicants choosing an alternative security pursuant to § 13-64-301(1)(e), C.R.S. the following shall be submitted:

1. In the event an applicant files a plan of self-insurance for multiple health care institutions and health care institution locations, the filing must clearly reflect that each individual health care institution and each individual health care institution location meets the minimum required coverage limits.

2. The name and address of each health care institution and each health care institution location.

3. A detailed explanation of the overall plan of operation of the self-insurance program, method of operation and coverage being offered including administrative procedures and expertise in administration, actuarial and claims analysis, including copies of all contracts and subcontracts.

4. Submission of an actuarial certification which includes a report setting forth any and all self-insurance exposures by a qualified actuary. The applicant may request a waiver of this requirement, but in no event may the period between certifications exceed two years.

5. An affidavit executed by a knowledgeable officer of the health care institution stating whether or not the figure within the statement of actuarial opinion has been stated in the institution's financial statements, and if so, to what extent.

6. Audited financial statements from the incorporation date to the present, but not to exceed the past three years, for the entity which will be liable for the self-insurance exposure risk, and consolidated financial statements for the entire organizational structure when the institution(s) is/are part of a holding company system.

7. An organizational chart of all related corporate entities when the applicant and the institution seeking to self-insure are members of a holding company system.

8. An explanation and listing of any and all pledges, commitments, letters of credit, or other documents executed by the health care institution or any entity within the holding company system, not reflected in the financial statements set forth above.

9. Any actuarial studies, reports, projections, feasibility studies, or justifications which the applicant believes further demonstrates adequacy of the self-insurance program, or any other document not requested above which the Commissioner deems necessary to fully evaluate the proposed plan of self-insurance.

10. An applicant may establish a trust as the funding mechanism under this Subsection F. The trust agreement must be submitted and approved and must be established with an

authorized trustee in a chartered state bank, savings and loan association, credit union, or trust company authorized to act as fiduciary and under the supervision of the State Bank and or Financial Services Commissioner or a national banking association, federal credit union, or federal savings and loan association authorized to act as fiduciary in Colorado. The trust must include provisions whereby termination may not occur without prior written consent of the Commissioner.

G. In the event an applicant has secured commercial liability insurance coverage pursuant to § 13-64-301(1)(b), C.R.S. and has retained a certain level of risk exposure prior to the commercial carrier being at risk, the self funded portion of the plan is subject to the filing requirements of Subsection F. The Colorado Department of Public Health and Environment will then give consideration to the overall combined risk retention design and commercial liability coverage.

H. In determining financial responsibility, the applicant's financial status will be reviewed to determine the ability not only to make payments when due, but also to determine current financial soundness. The information submitted will be reviewed to determine the acceptability of underlying assumptions used in determining plan obligations, that the plan obligations will be valued in accordance with commonly accepted actuarial practices and that the conservative nature and intent of statutory accounting standards will be utilized where appropriate in valuing assets used to support insurance responsibilities. The financial statements must establish good and sufficient provisions for all incurred and unmatured obligations of the health care institution.

Section 5 Evidence Of Compliance

A. The Commissioner shall issue a letter of approval for those health care institutions which meet the requirements under items D, E, or F of Section 4 of this regulation. Applicants not meeting the requirements shall be denied.

B. A letter of approval or denial from the Commissioner shall be remitted to the applicant and a copy sent to the Colorado Department of Public Health and Environment. A letter of denial shall state all reasons for the denial. The letter of approval, at a minimum, will include the following information:

1. The name and address of each health care institution and each health care institution location to whom the letter of approval is issued;

2. The form of financial responsibility approved by the Commissioner for use by the health care institution of either surety bond, cash or cash equivalent, other security, or plan of self-insurance;

3. A statement of compliance with at least the minimum mandated coverage amounts as specified in § 13-64-301 (1)(b), C.R.S.;

4. A determined effective and expiration date for the letter of approval;

5. A statement that the type of financial responsibility provided by the approved plan of operation is limited to medical malpractice liability coverage; and

6. A statement that the renewal submission for review by the Division of Insurance of the applicant's plan of self-insurance is due 60 days prior to the expiration date of the approval.

C. The Commissioner shall notify the applicant within 30 days of receipt of the application if any additional information is required and shall specify such additional information.

Section 6 Changes

Health care institutions must notify the Division of Insurance of financial responsibility plan changes at least 30 days prior to the effective date of the change. Changes requiring notification include, but are not limited to, name changes and location changes of health care institutions, address changes, changes in control of health care institutions, additions of health care institutions, deletions of health care institutions, changes in trust arrangements, changes in coverage and changes in management or administration.

Section 7 Confidentiality

A. Documents submitted in compliance with this regulation, shall generally be considered public records pursuant to § 24-72-201 through 206, C.R.S.

B. If an applicant considers a document to be exempt from disclosure, the applicant must submit the document under separate cover, conspicuously label each page “CONFIDENTIAL” , and provide a citation of legal authority for the exemption along with an explanation of how each document is covered by the exemption.

C. Documents which are exempt from the open records laws will be maintained in a separate, confidential file and will not be released to the general public for inspection or copying except upon court order or agreement of the applicant.

Section 8 Severability

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

Section 9 Effective Date

This amended regulation shall be effective on November 1, 1999.

Section 10 History

Originally promulgated

Amended and effective June 1, 1990.

Amended and effective November 1, 1999.

Amended Regulation 2-1-2 CONCERNING HOME OR REGIONAL HOME OFFICE QUALIFICATION FOR COLORADO LICENSED INSURERS

Section 1 **Authority**

Section 2 **Background and Purpose**

Section 3 **Forms**

Section 4 **Qualification Process**

Section 5 **On-Site Verification**

Section 6 **Standards**

Section 7 **Removal of Qualified Status**

Section 1 . Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § 10-1-109(1), C.R.S.

Section 2 . Background And Purpose

The intent and purpose of § 10-3-209(1)(b)(I)(B), C.R.S. is to provide a tax incentive for insurance companies to bring employment to the State of Colorado through the establishment of home or regional home offices (hereinafter referred to as RHO) in the state. It is not intended to furnish tax relief to companies that do not either perform the required level of the functions mandated by statute, or maintain significant direct insurance operations supported by functional operations pertinent to a line or lines of business written by the company.

The purpose of this regulation is to provide filing requirements and standards that are applicable to companies making application for RHO qualification.

Section 3 . Forms

A. The first year applicant may elect to file for qualification using either the " Long Form " application, which provides an extensive and detailed analysis of the applicant's operations, or the Significant Direct Insurance Operations application form, which requires the applicant to meet two (2) of three (3) standards pursuant to Section 6 (B.) of this regulation. If the applicant elects to qualify using the " Long Form, subsequent filings shall be made on a " Short Form for the next four years or until the Company's operations have changed in such a manner as to materially affect its regional home office operations. Every fifth year the company shall file a "Long Form" .

B. A complete application is required to be filed before any determination can be made, either for a new or renewal applicant. A complete application shall include the application form, all required original signatures, seals, and attachments specified by the application form and instructions. Due dates for the complete application must be in accordance with Section 4 of this regulation.

C. The company is required to notify the Colorado Division of Insurance of any material changes in operation which could affect their qualification within 30 days from the effective date of the change. Upon review of this information the Division of Insurance may require additional filings which may include the Long Form application if not already filed.

Once the application is approved, the applicant must attach a copy of its approval letter to each Premium Tax Filing form. Forms filed without this authorization will be subject to the tax rate required by statute (§ 10-3-209(1)(b)(I)(A), C.R.S.).

Section 4 . Qualification Process

A. All companies, except newly formed companies, must meet the qualification standards on January 1 of the year of application and continuously maintain qualification throughout the year.

B. Newly formed companies meeting the qualification standards from their inception may apply within sixty (60) days of the issuance of their certificate of authority for RHO qualification. If the new company is approved as a RHO, the effective date of approval will be the date the company was licensed.

C. New Applications must be received on or before December 31 preceding the calendar year for which the initial RHO qualification is being submitted. New applications will undergo a detailed review and an on-site verification, pursuant to the provisions of Section 5, of the company's performance of the mandated functions.

D. Renewal Applications must be received on or before March 1. Significant changes noted upon review by the Division may result in a request for a more detailed explanation, filing of the long form, and possible on-site verification. The request for additional information beyond that required by the application form does not affect the receipt date of the application.

E. Renewal applications, if approved will have an effective date of January 1.

F. Final written approval or disapproval of an RHO application will be made to the company within forty five (45) days from the date of the receipt of the application, request for additional information, or on-site verification, whichever occurs at the latest date.

G. Each company is expected to independently meet the qualification standards, however, affiliated or subsidiary companies as defined in § 10-3-801, C.R.S., performing similar operations in Colorado, sharing certain administrative and technical processes, can submit a single application which clearly identifies the company name and NAIC number for all entities applying for regional home office status.

Section 5 . On-Site Verification

A. At the discretion of the Commissioner all qualifying companies are subject to on-site inspection. The on-site verification will consist of an inspection of the premises of the Colorado office, verification of the information contained in the application, and an interview with the senior officers of the Colorado office.

B. On site inspections of a group application will include verification that all companies included in the application meet the required mandates.

Section 6 . Standards

Approval of an application requires compliance with the statutory mandate to “substantially” perform certain functions, or to maintain significant direct insurance operations supported by pertinent functional operations in this state. The applicant may qualify by complying with one of the following standards:

A. The statutory functions must be performed in Colorado for a minimum of three (3) entire states or all states in which the company is licensed, if less than three. The level of performance considered substantial is defined as not less than 66% (two-thirds) of the nine functions described in § 10-3-209(1)(b)(I)(B)(II)(A), C.R.S. This level of performance shall apply to the number of functions, the degree of performance of these functions, and other significant criteria particular to each company. Analysis of a company's compliance with this standard includes a review of the performance of these functions for each significant line of business transacted within the region.

The nine mandated functions described in section 10-3-209(1)(b)(II), C.R.S. consist of various sub-functions and tasks. Applicant is required to define its performance of each of the mandated functions and various sub-functions and tasks of each function to qualify, taking into account the line or lines of business the applicant transacts in the region. An applicant's definition of the

performance of each function may differ, depending upon the type and nature of the applicant's business.

B. Maintenance of significant direct insurance operations supported by functional operations that are both necessary and pertinent to a line or lines of business written by the applicant. The functional operations for a line or lines of business written must be substantially equivalent to the functions in § 10-3-209(1)(b)(II), C.R.S., and must be representative of the type of insurance being written. To substantiate compliance with the maintenance of significant direct insurance operations, the applicant must provide adequate documentation substantiating that two (2) of the following three (3) requirements are met by either the applicant or the applicant's ultimate parent, subsidiary or affiliate as defined in § 10-3-801, C.R.S,

1. Maintain a work force of one hundred and fifty (150) individuals, per each regional home office applicant company, located in Colorado, comprised of full time employees, excluding agents and their staff, or

2. Own, or lease, office space in Colorado equivalent to 30,000 square feet per each regional home office applicant company, or

3. Expend, for salaries, administration, operating expenses, etc., not less than five (5) million dollars per each applicant company in this state related to the performance of functional operations.

For multiple companies with the same ultimate parent, subsidiary or affiliate the applicant must be able to demonstrated that each applicant would meet the requirements if it directly employed the full time employees; directly owned or leased the office space or directly expended the minimum funds for operations.

C. If the applicant has made application under either standard 6 (A.) or 6 (B) of this regulation, and fails to qualify, no other application shall be considered for the same year.

Section 7. Removal Of Qualified Status

A. A company will no longer qualify as an RHO upon its notification to the Division of Insurance that it no longer maintains an office in this state; upon failure to file the required application; upon the Division's determination of noncompliance with the standards established for qualification as a RHO resulting in a letter of denial; or by a change in the company's operations which impairs qualification.

B. Upon the determination that the company no longer meets the qualification standards of a RHO, the 1% premium tax rate will be granted for the amount of the actual premium written prior to the date that the qualification is lost. The company is responsible for providing sufficient and acceptable documentation to support the amount of premium written prior to such date. If the date cannot clearly be determined, the rescission will be backdated to January 1 of the current year.

C. In the event the RHO no longer qualifies for the 1% premium tax rate and has already prepaid estimated quarterly taxes at the 1% rate, the company must make payment of any deficient quarterly payment in conjunction with the next subsequent quarterly (or year end) payment.

Section 8 . Administrative Appeal

A. A company which receives a letter from the Division of Insurance denying or revoking the RHO status may appeal by submitting in writing, to the Division of Insurance, a petition setting forth detailed explanations and support of the company's position that the denial was in error.

B. If the initial denial is affirmed by the Division of Insurance, the company may file a written request for an administrative hearing, pursuant to § 24-4-105, C.R.S.

C. Appeal actions exercised by the company must be submitted within thirty (30) days from the date of the most recent letter of denial.

Section 9 . Enforcement

Noncompliance with this regulation may result in the imposition of an assessment comprised of premium taxes due and payable at the standard premium tax rate, plus interest and an additional penalty.

Section 10 . Severability

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

Section 11 . Effective Date

This regulation is effective on January 1, 2002.

Section 12 . History

Amended and Restated December 31, 1996.

Amended effective January 1, 2002.

REGULATION 2-1-3 CONCERNING THE FINANCIAL RESPONSIBILITY REQUIREMENTS FOR HEALTH CARE PROFESSIONALS

I. AUTHORITY

This regulation is promulgated under the authority of § § 10-1-109, 10-1-108 (8), 13-64-301, and 12-40-126, Colorado Revised Statutes (C.R.S.).

II. DEFINITIONS

“Applicant” as used in this regulation means a physician licensed by the board of medical examiners, a dentist licensed by the board of dental examiners, an optometrist licensed by the board of optometric examiners, or a corporation or other entity which is assuming the exposure risks of the underlying licensed physicians, dentists, or optometrists.

“Commissioner” as used herein means the Colorado Commissioner of Insurance

“Professional malpractice” for purpose of this regulation shall mean those medical malpractice claims arising out of the professions of physicians, dentists and optometrists.

“Professional” as used herein means a physician, dentist or optometrist.

III. BASIS AND PURPOSE

Effective July 1, 1988 the Health Care Availability Act, § 13-64-101, et seq., C.R.S., and § 12-40-126, C.R.S. were amended prescribing financial responsibilities for optometrists and other health care professionals. The legislative declaration for these bills declared that they were enacted for the purpose of assuring continued availability of adequate health care services for the people of Colorado by containing the significantly increasing costs of professional malpractice insurance for licensed professionals, and that

such is rationally related to a legitimate state interest.

The purpose of this regulation is to identify, for the applicant, the documents and information required to establish financial responsibility for review by the Commissioner of Insurance, in compliance with § § 13-64-301 (1), (c), (d) and (e), C.R.S. and 12-40-126 (1)(b), (c) and (d), C.R.S.

The financial liability requirements are mandated in § § 13-64-301, and 12-40-126 C.R.S. for applicants which are not specifically exempted under the Colorado Governmental Immunity Act, or otherwise exempted under the statute. Sections 13-64-301 and 12-40-126 provide that an applicant, in order to maintain condition of active licensure, maintain one of the following forms of coverage:

(1) commercial professional liability insurance coverage

(2) a surety bond

(3) cash or cash equivalents

(4) any other security, acceptable to the commissioner, which may include a plan of self insurance.

IV. REQUIREMENTS FOR ESTABLISHING FINANCIAL RESPONSIBILITY

Each filing must be submitted by the applicant to the Corporate Affairs Section of the Division of Insurance for review at least sixty (60) days prior to the expiration date of the professional license with the appropriate licensing board.

The submission shall include a detailed explanation of the overall plan of operation, method of compliance, whether coverage is to be on an occurrence or claims-made basis, administrative procedures, including copies of any contracts and subcontracts related to the plan of financial responsibility.

Where the coverage is being offered on a claims-made basis, the coverage must meet the requirements of § 10-4-419, C.R.S., where applicable.

The board of medical examiners, the board of dental examiners or the board of optometric examiners may establish financial responsibility standards which are less than those prescribed in § § 13-64-301 and 12-40-126, C.R.S.. If the applicant is filing for reduced financial responsibility standards, he/she must submit authorization for such standards from the appropriate licensing board.

A. Surety Bonds

The following information must be provided to the Commissioner by any applicant posting a surety bond as the method of financial compliance:

1. A copy of the executed bond which must clearly set forth:

   a. The name of the insurance company, which is authorized to operate in the State of Colorado, issuing the bond;

   b. The amount of the bond;

   c. The type of bond;

   d. That said bond is issued in favor of third party claimants against the applicant for payments of professional malpractice settlements;

e. The bond shall provide for 90 days advance notice to the Commissioner in the event of cancellation or nonrenewal.

2. Evidence satisfactory to the Commissioner that the amount of the bond is sufficient to fund the applicant's current license year obligation of $500,000 per incident/$1,500,000 aggregate per year plus whatever remaining liability there may be for prior year's coverage.

B. Cash or Cash Equivalent

The form of cash or cash equivalents deposited by any applicant must be approved by the Commissioner. The funds shall be held under joint control with the Commissioner pursuant to § 10-3-210, C.R.S. The market value shall be sufficient to fund the applicant's current license year obligation of $500,000 per incident/$1,500,000 aggregate per year plus whatever remaining liability there may be for prior year's coverage.

C. Other Security, which may include plans of self insurance

1. In order to determine the adequacy of financial ability for those applicants choosing another form of security, the applicant shall submit the following:

a. The name, address, license number, (if available), and effective dates of the licensure period of the applicant.

When the applicant is a corporation or other entity, the application must contain a list of all covered professionals, license numbers, renewal/licensing dates, and appropriate documentation which creates the legal obligation to cover the listed professionals.

b. Submission of an actuarial report by a qualified actuary which sets forth exposures, funding methodology, and recommendations for the adequacy of funding level and loss adjustment expense reserves.

c. Financial statements for the past three years for the person or entity which will be liable for the exposure risk, including balance sheets, income statements and changes of financial position or equivalent statements and detail certified by an independent public accountant.

d. Any actuarial studies, reports, projections, feasibility studies, or justifications which the applicant believes further demonstrates adequacy of the program, or any other document not requested above which the Commissioner of Insurance deems necessary to fully evaluate the proposed plan.

2. An applicant may establish a trust as the funding mechanism under this subsection C. The trust agreement must be submitted and approved and must be established with an authorized trustee in a chartered state bank, savings and loan association, credit union, or trust company authorized to act as fiduciary and under the supervision of the state bank and savings and loan commissioner or a national banking association, federal credit union, or federal savings and loan association authorized to act as fiduciary in Colorado. The trust must include provisions whereby termination may not occur without prior written consent of the Commissioner.

3. In determining financial responsibility under this subsection C, the applicant's financial status will be reviewed to determine the ability not only to make payments when due, but also to determine current financial soundness. The information submitted will be reviewed to

determine the acceptability of underlying assumptions used in determining plan obligations, that the plan obligations will be valued in accordance with commonly accepted actuarial practices and that the conservative nature and intent of statutory accounting standards will be utilized where appropriate in valuing assets used to support insurance responsibilities. The financial statements must establish good and sufficient provisions for all incurred and unmatured obligations of the applicant.

V. EVIDENCE OF COMPLIANCE

A. The Commissioner shall issue a letter of approval for those applicants who meet the requirements under items A, B or C of section IV of this regulation. Applicants not meeting the requirements shall be denied.

B. A letter of approval or a denial thereof from the Commissioner shall be remitted to the applicant and copied to the appropriate licensing board. A letter of denial shall state all reasons therefor. The letter of compliance, will include the following information:

1. The name and address of the applicant, including all professionals covered in the case of group submissions, and the professional license number of those whom the evidence of compliance is issued for;

2. The form of financial responsibility approved by the Commissioner for use by the professional as either surety bond, cash or cash equivalent or other security, which may include a plan of self insurance;

3. A statement that the applicant has demonstrated the ability to satisfy the minimum coverage amounts as specified in § 13-64-301 (1), or § 12-40-126 (1) C.R.S.;

4. A determined effective and expiration date for the evidence of compliance;

5. That the type of financial responsibility provided by the approved plan of operation is limited to professional malpractice liability coverage; and

6. That renewal submissions for review by the Division of Insurance of the applicant is due 60 days prior to the expiration date of the evidence of compliance.

C. The Commissioner shall notify the applicant within 30 days of receipt of the application if any additional information is required and shall specify such additional information.

VI. CONFIDENTIALITY

Documentation requested by the Division of Insurance and submitted in compliance herewith, shall generally be considered a public record under the public records act, § 24-72-201 through 206, C.R.S.

In the event any requested documentation is considered by the applicant to be confidential in nature, the applicant must submit the requested information under separate cover or in a sealed envelope or file clearly labeled “CONFIDENTIAL.” Attached to the documents submitted under confidential cover should be a brief, typed explanation of why they are to be considered confidential.

Documentation so submitted, if found to be confidential in nature by the Division of Insurance, will be maintained in a separate, confidential file and will not be released to the general public for inspection or copying.

VII. PROCEDURE FOR APPEAL

A decision of the Commissioner under this regulation shall be subject to appeal as provided for under the Colorado Administrative Procedures Act.

VIII. SEVERABILITY

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

IX. EFFECTIVE DATE

This regulation shall be effective on January 1, 1990.

Regulation 2-1-4 CONCERNING THE ENTRY OF ALIEN INSURANCE COMPANIES IN COLORADO - Repealed Effective 03/01/2012

Amended Regulation 2-1-5 CONCERNING ANNUAL APPLICATION FOR APPROVAL AS AN AUTHORIZED NONADMITTED REINSURER AND RESERVE CREDIT FOR MANDATED POOLS

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109 C.R.S., and 10-3-118(6) C.R.S.

Section 2 Background And Purpose

This regulation sets the form and content of the application for an insurer to be accredited as a reinsurer in Colorado. The regulation also sets the conditions under which an insurer may take a reserve credit for participation in a mandated insurance pool.

Section 3 Rules

A. Filing Requirements

1. Foreign reinsurers and branch operations of alien reinsurers, authorized to transact business in at least one state of the United States and filing under the provisions of § 10-3-118(4)(c) C.R.S., shall submit to the Division of Insurance a complete, executed application form, including Form AR-1 Certificate of Assuming Insurer and the information required by § 10-3-118(4)(c), C.R.S.

2. Alien reinsurers maintaining trust funds and filing under the provisions of § 10-3-118(4)(f), C.R.S. shall provide the following items in order to make a complete application:

a. A complete executed application form, including Form AR-1 Certificate of Assuming Insurer.

b. A copy of the applicant's most recent financial statement. Such statement shall contain the information substantially the same as that required to be reported in the NAIC annual statement form by licensed insurers, to enable the Commissioner to determine the sufficiency of the trust fund. All values must be reported in U.S. currency.

c. A copy of the trust instrument, which shall comply with § 10-3-118(4)(f), Colorado Revised Statutes. The trust must be in a qualified United States Financial Institution for the benefit of all U.S. ceding insurers.

d. Any amendments to the trust instrument must have been approved by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust.

3. The Commissioner may request other information which is deemed necessary to analyze the acceptability of the application.

4. Forms referenced above are available from, and all applications shall be submitted to, the Corporate Affairs Section of the Colorado Division of Insurance.

5. The check for the fee under § 10-3-207, C.R.S., shall be drawn on a United States bank in U.S. dollars.

6. All applicants will receive notice of acceptability or a notice of denial that will indicate the basis for such denial within ninety days after their submission.

B. Mandated Pools

This section shall apply when an insurer, as a condition of its license in a particular jurisdiction, is required to participate in a reinsurance arrangement by the applicable laws of such jurisdiction. Such reinsurance pool will be considered to be accredited and reserve credits permitted with respect to the insurance of risks located in such jurisdiction, subject to the following:

1. Any reinsurance arrangement which is backed by the full faith and credit of the jurisdiction shall be deemed accredited. It is the responsibility of the member insurer to provide such evidence upon request.

2. In other reinsurance arrangements the member ceding insurer may take full reserve credit for such cession provided the member insurers are jointly and severally liable for the obligations of the pool and the ceding insurer establishes the full amount of the accrued liabilities for their participation in the pool. It is the responsibility of the member insurer to provide such evidence upon request.

Section 4 Severability

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

Section 5 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of

the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in § 10-3-1108, C.R.S. may be applied.

Section 6 Effective Date

This regulation shall be effective January 1, 2006.

Section 7 History

Originally regulation 90-9, effective September 1, 1990.

Amended effective October 1, 1992.

Amended effective August 31, 1994.

Amended effective March 1, 2000.

Amended effective January 1, 2006.

Regulation 2-1-7 CONCERNING ISSUANCE OF A CERTIFICATE OF AUTHORITY

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-14-505, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to clarify the standards for issuing certificates of authority to transact insurance business in Colorado to insurers, fraternal benefit societies and interinsurance exchanges.

Section 3 Applicability

This regulation applies to any company seeking a Certificate of Authority as a property, casualty, multiple line, life or title insurer, fraternal benefit society or interinsurance exchange, or any such company seeking to add lines of business, redomesticate, change its name or otherwise amend its Certificate of Authority.

Section 4 Application by Foreign Insurers

A. Any foreign company seeking a Certificate of Authority in Colorado as an insurer, fraternal benefit society, or interinsurance exchange shall submit a UCAA expansion application.

B. An applicant's capital and surplus must meet or exceed the minimum required by Colorado statute. Section 10-3-201, C.R.S. establishes the minimum amount of capital and surplus for each company type. The Division will review both the applicant's company type as determined by its state of domicile and the lines of business that it currently writes. The Division will determine the minimum required under each of these scenarios and apply the greater of the two amounts. For example, an insurer licensed as a multiple line carrier by its state of domicile, which currently only writes casualty lines of business as defined by a Colorado certificate of authority, would be considered a multiple line carrier in Colorado. As such the company would need to meet the capital and surplus requirement for a multiple line company.

C. If the company's operation is predominately that of a reinsurer the surplus requirements of a reinsurer pursuant to § 10-3-118, C.R.S. must be met. The $20 million surplus requirement shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

D. The applicant must demonstrate the ability to maintain the minimum level of capital and surplus at the time of initial licensure and on an on-going basis. This includes the ability to fund for product development and for other causes of surplus strain resulting from increasing business writings or new business ventures. An amount in excess of the statutory minimum capital and surplus is necessary at the time of licensure to ensure that the company has a sufficient cushion to absorb any surplus strain. Generally, the applicant should have three (3) times the authorized control level based on the most recent annual risk based capital calculation.

E. The applicant must have a sound business plan, sufficient capital to support the plan, and adequate access to additional capital. In addition, the applicant must also demonstrate favorable liquidity, adequate reinsurance from companies authorized in this state, sound management, at least three years of favorable operating results, and stable revenue, earnings and surplus trends. The commissioner may waive the three years of favorable operating results requirement if the applicant:

1. Is the wholly owned subsidiary of an insurance company authorized to transact insurance in the State of Colorado, or

2. Is the successor in interest through merger or consolidation of an insurance company authorized in Colorado, or

3. Is seeking authority to write only crop insurance policies reinsured by the Federal Crop Insurance Corporation and the applicant company is designated by the United States Department of Agriculture to provide insurance coverage through the Standard Reinsurance Agreement, or

4. Is seeking authority to write a line, or lines, of insurance business that is underserved in this state. Any applicant seeking a waiver of the three years of favorable operating results requirement pursuant to this provision shall supplement the other required application

documents with the following:

a. Information and documentation as may be necessary to demonstrate to the Commissioner that there is no reasonable or adequate market among authorized insurers for the type of coverage involved in the request

b. Documentation that the applicant possesses the financial capability to adequately fund the loss and underwriting costs associated with the type of coverage involved

c. A certification from the applicant acknowledging that if the requested waiver is approved, the applicant's authority to transact business shall be limited to the line, or lines of business and type, or types, of coverage involved in the request

F. The commissioner may require an actuarial opinion and a surplus sufficiency report prior to licensure or at any time after licensure when the commissioner believes that there is a need to review the adequacy of the available surplus with respect to the types of assets and writings of the company. A company seeking licensure must be authorized by its domiciliary state to write the lines of insurance being requested and demonstrate that it possesses the expertise necessary to write and service such insurance. An applicant who is increasing its market to include new products is also required to demonstrate the necessary expertise. The commissioner may waive this requirement if the company is affiliated with a company licensed in Colorado that writes the same type of insurance being requested. An applicant may be required to provide a guaranty on a form prescribed by the commissioner, to maintain surplus either at the amount required by statute or three (3) times the authorized control level based on the most recent annual risk based capital calculation, whichever is greater.

H. The commissioner may require any applicant, or affiliated company of the applicant to remedy any hazardous financial condition as outlined in Regulation 3-1-7 prior to licensure.

I. Substantial errors, fraudulent statements contained in an application or incomplete applications constitute sufficient grounds for denial of the application.

J. The most recent financial examination of the applicant must have a date of account no later than five years from the date of the application for licensure.

Section 5 Formation of a Colorado Domestic Insurer

A. An application for the formation of a Colorado domestic insurance company as an insurer, fraternal benefit society, or interinsurance exchange must be the UCAA primary application. The applicant company's plan of operation narrative must include an explanation of how § 10-3-128(1), C.R.S. requirements will be fulfilled.

B. The applicant must demonstrate the ability to maintain the minimum level of capital and surplus at the time of initial licensure and on an on-going basis. This includes the ability to fund for product development and for other causes of surplus strain resulting from increasing business writings or new business ventures. An amount in excess of the statutory minimum capital and surplus is necessary at the time of licensure to ensure that the company has a sufficient cushion to absorb any surplus strain. Generally, the applicant should have three (3) times the authorized control level based on the most recent annual risk based capital calculation.

C. If the company's operation is predominately that of a reinsurer the surplus requirements of a reinsurer pursuant to § 10-3-118, C.R.S. must be met. The $20 million surplus requirement shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

D. The applicant must have a sound business plan, sufficient capital to support the plan, and adequate access to additional capital. In addition, the applicant must also demonstrate favorable liquidity, adequate reinsurance from companies authorized in this state, sound management, and stable revenue, earnings and surplus trends.

E. The commissioner may require an actuarial opinion and report of the company's surplus adequacy prior to licensure or at any time during which the company is licensed when it is believed that there is a need to review the adequacy of the available surplus with respect to the types of assets and writings of the company.

F. Substantial errors, fraudulent statements contained in an application or incomplete applications constitute sufficient grounds for denial of the application.

Section 6 Change to Existing Authority

A. A company may submit a UCAA corporate amendments application to add or delete lines of business, redomesticate, change its name or otherwise amend its Certificate of Authority.

B. The Commissioner will determine whether the company has the necessary expertise, experience and financial ability for continued licensure in Colorado after the proposed change.

Section 7 Reinstatement of Suspended Authority

Any suspended foreign or domestic insurer, fraternal benefit society or interinsurance exchange may have its certificate of authority reinstated by demonstrating that it meets all the conditions and standards for licensure. Applications must be on a form prescribed by the Commissioner.

Section 8 Confidentiality

A. Documents submitted in compliance with this regulation, shall generally be considered public records under the public records act, § 24-72-200.1, C.R.S., et seq.

B. If an applicant considers a document to be confidential, the applicant must submit the document under separate cover clearly labeled "CONFIDENTIAL" with an explanation of why the applicant believes the documents are confidential.

C. Documentation found to be confidential by the Division will be maintained in a separate, confidential file and will not be released to the general public for inspection or copying except upon court order or agreement of the applicant.

Section 9 Severability

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

Section 10 Enforcement

Non compliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license.

Section 11 Effective Date

This amended regulation shall be effective March 1, 2012

Section 12 History

Originally adopted November 1, 1990.

Amended September 1, 1992.

Amended March 1, 1994.

Amended November 1, 1999.

Amended September 1, 2002.

Amended March 1, 2012.

AMENDED REGULATION 2-1-8 CONCERNING RISK RETENTION GROUPS AND PURCHASING GROUPS

Section 1. AUTHORITY

This regulation is promulgated and adopted by the Colorado Commissioner of Insurance (Commissioner) under the authority of § § 10-1-108(8), 10-1-109 and 10-3-1403, C.R.S.

Section 2. PURPOSE

The purpose of this regulation is to regulate the formation and/or operation of risk retention groups or purchasing groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986, 15 U.S.C. 3901 et seq ("RRA 1986"), to the extent permitted by such law.

Section 3. SCOPE

This regulation shall apply to any insurance company or purchasing group eligible or seeking to become eligible to operate under the RRA 1986 in Colorado.

Section 4. DEFINITIONS

As used in this regulation

A. "Completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by

1. any person who performs that work; or

2. any person who hires an independent contractor to perform that work; but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

B. "Domicile", for purposes of determining the state in which a purchasing group is domiciled, means for a corporation, the state in which the purchasing group is incorporated; and for an unincorporated entity, the state of its principal place of business.

C. "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or to pay other obligations in the normal course of business.

D. "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state.

E. "Liability" means legal liability for damages (including costs of defense, legal costs and fees, and other claims expenses) because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of any business (whether profit or nonprofit), trade, product, services (including professional services), premises, or operations; or any activity of any state or local government, or any agency or political subdivision thereof; but does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. 51 et seq.).

F. "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in Section 4 E.

G. "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

1. information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;

2. for each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

3. historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

4. pro forma financial statements and projections;

5. appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

6. identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements;

7. identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and

8. such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

H. "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

I. "Purchasing group" means any group which

1. has as one of its purposes the purchase of liability insurance on a group basis;

2. purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph (3) below;

3. is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

4. is domiciled in any state.

J. "Risk retention group" means any corporation or other limited liability association:

1. whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

2. which is organized for the primary purpose of conducting the activity described in the previous paragraph;

3. which

a. is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

b. before January 1, 1985 was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability (as such terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of RRA of 1986);

4. which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

5. which

   a. has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

   b. has as its sole owner an organization which has as

      i. its members only persons who comprise the membership of the risk retention group; and

      ii. its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

6. whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, services, premises or operations;

7. whose activities do not include the provision of insurance other than

   a. liability insurance for assuming and spreading all or any portion of the liability of its group members; and

   b. reinsurance with respect to the liability of any other risk retention group (or any members of such other group) which is engaged in businesses or activities so that such group or member meets the requirement described in section IV(J)(6) for membership in the risk retention group which provides such reinsurance; and

8. the name of which includes the phrase "Risk Retention Group".

K. "State" means any state of the United States or the District of Columbia.

L. "NAIC" means National Association of Insurance Commissioners.

Section 5. RISK RETENTION GROUPS CHARTERED IN THIS STATE

A. A risk retention group shall be chartered and licensed to write only liability insurance as limited by RRA 1986 and, except as provided elsewhere in this regulation, must comply with all of the laws, rules, regulations and requirements applicable to insurers chartered and licensed in this state and with Section 6 of this regulation to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this state.

B. Notwithstanding any other provision to the contrary, all risk retention groups chartered in this state

shall file with the Division and the NAIC, an annual statement in a form prescribed by the Commissioner and in diskette form, if required by the Commissioner and completed in accordance with its instructions.

C. Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Commissioner a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within ten (10) days of any such change. The group shall not offer any additional kinds of liability insurance, in this state or in any other state, until a revision of such plan or study is approved by the Commissioner.

D. At the time of filing its application for license, and in addition to the filing requirements of Colorado Insurance Regulation 2-1-7 the risk retention group shall provide to the Commissioner in summary form the following information: the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. An additional copy of this information shall be filed and upon receipt of this information, the Commissioner shall forward the information to the NAIC. Providing notification to the NAIC is in addition to and shall not be sufficient to satisfy the requirements of Section 6 or any other requirements of this regulation.

Section 6. RISK RETENTION GROUPS NOT CHARTERED IN THIS STATE

Risk retention groups chartered and licensed in states other than this state and seeking to do business as a risk retention group in this state shall comply with the laws of this state as follows:

A. Notice of Operations and Designation of Commissioner as Agent.

1. Before offering insurance in this state, a risk retention group shall submit to the Commissioner on a form prescribed by the Commissioner:

   a. a statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, charter date, its principal place of business, and such other information, including information on its membership, as the Commissioner may require to verify that the risk retention group is qualified under subsection 4. J. of this regulation;

   b. a copy of its plan of operations or feasibility study and revisions of such plan or study submitted to the state in which the risk retention group is chartered and licensed; provided, however, that the provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which:

      i. was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

      ii. was offered before such date by any risk retention group which had been chartered and operating for not less than three years before such date; and

2. The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by subsection 6.A.1.b. of this regulation at the same time that such revision is submitted to the commissioner of its chartering state.

3. The risk retention group shall submit a statement of registration, which designates the Commissioner as its agent for the purpose of receiving service of legal documents or process.

4. The risk retention group shall submit a resolution of the board of directors, certified by the corporate secretary or equivalent officer, which designates the Commissioner as agent for the purpose of receiving service of legal documents or process.

B. Financial Condition. Any risk retention group doing business in this state shall submit to the Commissioner:

1. a copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a qualified actuary;

2. a copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

3. upon request by the Commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

4. such information as may be required to verify its continuing qualification as a risk retention group under Section 4. J.

C. Taxation.

1. Each risk retention group shall be liable for the payment of premium taxes on business for risks resident or located within this state, and shall report to the Commissioner the gross premiums written for risks resident or located within this state. The risk retention group shall be subject to taxation, and any applicable fines and penalties related thereto, on the same basis as a foreign admitted insurer.

2. To the extent licensed agents or brokers are utilized, they shall report to the Commissioner the premiums for direct business for risks resident or located within this state which the licensees have placed with or on behalf of a risk retention group not chartered in this state.

3. To the extent that insurance agents or brokers are utilized, the agent or broker shall keep a complete and separate record of all policies procured from each risk retention group, which record shall be open to examination by the Commissioner, as provided in § 10-1-201, C.R.S. These records shall, for each policy and each kind of insurance provided thereunder, include the following:

a. the limit of liability;

b. the time period covered;

c. the effective date;

d. the name of the risk retention group which issued the policy;

e. the gross premium charged; and

f. the amount of return premiums, if any.

D. Any risk retention group shall comply with the laws of this state (§ 10-3-1104, C.R.S.) regarding unfair, deceptive, false or fraudulent acts or practices. However, if the Commissioner seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

E. Any risk retention group must submit to an examination by the Commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty (60) days after a request by the Commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the policies and procedures for examinations by the Colorado Division of Insurance.

F. Every application form for insurance from a risk retention group, and every policy (on its front and declaration pages) issued by a risk retention group, shall contain in ten point type the following notice:

NOTICE THIS POLICY IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

G. The following acts by a risk retention group are hereby prohibited:

1. The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

2. The solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

H. No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

I. The terms of any insurance policy issued by any risk retention group shall not provide, or be construed to provide, coverage prohibited generally by statute of this state or declared unlawful by the highest court of this state whose law applies to such policy.

J. A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under subsection 6. E. of this regulation.

K. A risk retention group that violates any provision of this regulation will be subject to fines and penalties including revocation of its right to do business in this state, applicable to licensed insurers generally.

Section 7. COMPULSORY ASSOCIATIONS

A. No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state, nor shall any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by such risk retention group.

B. When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state shall be covered by the state guaranty fund subject to § 10-4-501 et seq, C.R.S.

C. When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks, wherever resident or located, shall be covered by any insurance guaranty fund or similar mechanism in this state.

Section 8. PURCHASING GROUPS - EXEMPTION FROM CERTAIN LAWS

A purchasing group and its insurer or insurers shall be subject to all applicable laws of this state, except that a purchasing group and its insurer or insurers shall be exempt, in regard to liability insurance for the purchasing group, from any law that would:

A. prohibit the establishment of a purchasing group;

B. make it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters;

C. prohibit a purchasing group or its members from purchasing insurance on a group basis described in subsection B of this Section;

D. prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

E. require that a purchasing group must have a minimum number of members, common ownership or affiliation, or certain legal form;

F. require that a certain percentage of a purchasing group must obtain insurance on a group basis;

G. otherwise discriminate against a purchasing group or any of its members; or

H. require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in this state.

Section 9. NOTICE AND REGISTRATION REQUIREMENTS OF PURCHASING GROUPS

A. A purchasing group which intends to do business in this state shall, prior to doing business, furnish notice to the Commissioner which shall, on forms prescribed by the Commissioner:

1. identify the state in which the group is domiciled;

2. specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

3. identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of such company;

4. specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

5. identify the principal place of business of the group; and

6. provide such other information as may be required by the Commissioner to verify that the purchasing group is qualified under subsection 4. I. of this regulation.

B. A purchasing group shall, within ten (10) days, notify the Commissioner of any changes in any of the

items set forth in subsection A of this Section.

C. The purchasing group shall register and designate the Commissioner as its agent soley for the purpose of receiving service of legal documents or process, accompanied by a Board of Directors resolution authorizing the power of attorney, except that such requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the federal Products Liability Risk Retention Act of 1981, and:

1. which in any state of the United States was domiciled before April 1, 1986; and is domiciled on and after October 27, 1986;

2. which before October 27, 1986 purchased insurance from an insurance carrier licensed in any state; and since October 27, 1986 purchased its insurance from an insurance carrier licensed in any state; or

3. which was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986.

D. Each purchasing group that is required to give notice pursuant to subsection A of this section shall also furnish such information as may be required by the Commissioner to:

1. verify that the entity qualifies as a purchasing group;

2. determine where the purchasing group is located; and

3. determine appropriate tax treatment.

Section 10. RESTRICTIONS ON INSURANCE PURCHASED BY PURCHASING GROUPS

A. A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

B. A purchasing group which obtains liability insurance from an approved surplus lines carrier or a risk retention group shall inform each of the members of such group which have a risk resident or located in this state that such risk is not protected by an insurance insolvency guaranty fund in this state, and that such risk retention group or such insurer may not be subject to all insurance laws and regulations of this state.

C. No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

D. Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

Section 11. PURCHASING GROUP TAXATION

Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing groups shall be:

A. imposed at the same rate and subject to the same interest, fines and penalties as that applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

B. paid first by such insurance source, and if not by such source by the agent or broker for the purchasing group, and if not by such agent or broker then by the purchasing group, and if not by such purchasing group then by each of its members.

Section 12. ADMINISTRATIVE AND PROCEDURAL AUTHORITY REGARDING RISK RETENTION GROUPS AND PURCHASING GROUPS

The Commissioner may make use of any of the provisions of Title 10 of the Colorado Revised Statutes to enforce the laws of this state not specifically preempted by the RRA 1986 including the Commissioner's administrative authority to investigate, issue subpoena, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. With regard to any investigation, administrative proceedings or litigation, the Commissioner will rely on the procedural laws of this state.

Section 13. SEVERABILITY

If any clause, sentence, paragraph, section or part of this regulation or the application thereof to any person or circumstances, shall, for any reason, be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder of this regulation, and the application thereof to other persons or circumstance, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered and to the person or circumstances involved.

Section 14. EFFECTIVE DATE

This regulation is hereby amended and restated and shall become effective on April 1, 2004.

Section 15. HISTORY

Regulation amended and restated effective December 1, 1992

Amended effective April 1, 2004

Regulation 2-1-9 Licensure of Limited Service Licensed Provider Networks [Eff. 1/1/09]

Section 1 Authority

This regulation is promulgated under the authority of § § 6-18-302(1)(b), 10-1-108(13)(a) , 10-1-109(1), and 10-16-109, C.R.S., et seq.

Section 2 Scope and Purpose

In 1994, the Colorado General Assembly passed HB 94-1193 which authorized the commissioner through regulation to set forth standards and requirements specific to "licensed provider networks" (i.e., provider networks engaged in the business of insurance) concerning their solvency and operational capacity or the performance of services consistent with the extent of risk being accepted by the licensed provider network.

Provider networks desiring to provide only a limited health service, in-patient hospital services, or home health care, and only assume the level of risk commensurate with the provision of these limited benefits, shall be licensed as limited service licensed provider networks pursuant to standards and requirements established by this regulation.

The intent and purposes of this regulation are to establish requirements for licensure as a limited service licensed provider network, and to clarify the application of health benefit mandates and Title 10 requirements to limited service licensed provider network health coverage plans.

Section 3 Definitions

As used in this regulation, unless the context otherwise requires, the following definitions shall apply:

A. "Capitation" means an arrangement whereby the amount of money paid to the provider network is based upon the agreement to provide certain health care services to covered persons but does not vary on the basis of the number or type of services actually rendered.

B. "Carrier" shall have the same meaning as in § 10-16-102(8) C.R.S.

C. "Covered Person" shall have the same meaning as in § 10-16-102(13.5), C.R.S.

D. "Employee assistance program" shall mean a worksite-focused program designed to assist (1) work organizations in addressing productivity issues and (2) employee clients in identifying and resolving personal concerns (including, but not limited to health, marital, family, financial, alcohol,

drug, legal, emotional, stress, or other personal issues) which may affect job performance.

E. “Health Care Coverage Plan” shall have the same meaning as in § 10-16-102(22.5), C.R.S.

F. “Home health care services” shall mean the following services when provided to a covered person in his/her place of residence: skilled nursing services; home health aide services; provision of medical supplies, equipment, and appliances suitable for use in the home; and physical therapy, speech and hearing therapy, or occupational therapy.

G. “Incidental services” include fees only for x-rays, laboratory services, medications, and other services as approved by the commissioner.

H. “Inpatient hospital services” shall mean services provided by a licensed hospital to anyone requiring twenty-four (24) hours or more of continuous care in the facility.

I. “Limited service licensed provider network” (LSLPN) means a provider network that offers to contract directly with a consumer(s) (e.g., individual, group, employer, etc.) or their representative(s), to provide health care services restricted to (i) a narrowly defined health specialty (e.g., substance abuse, radiology, mental health, pediatrics, pharmacology, etc.) or (ii) services narrowly limited to a single type of licensed health facility (e.g., inpatient hospital, birth center, long term care facility, hospice, etc.), or (iii) home health care services delivered in the covered person's residence only. The services provided by the LSLPN must be limited in scope and must be significantly less than the basic health care services offered by a health maintenance organization or under a comprehensive or major medical policy. An LSLPN must be licensed as an insurance company pursuant to this regulation. Family Practitioners, Independent Practice Associations (IPAs) consisting of providers licensed in more than one specialty, or other similar medical/health collaborations do not meet the definition of a narrowly defined health specialty and therefore may not seek licensure under this limited license.

J. “Limited service licensed provider network health coverage plan” (LSLPN health coverage plan) means a contract, policy, certificate, or agreement entered into or issued by an LSLPN that agrees to assume the risk for specific, limited health care expenses and/or provide delivery of such services.

K. “Producer” shall have the same meaning as in § 10-2-103(6), C.R.S.

L. “Provider Network” shall have the same meaning as in § 6-18-301.5(3), C.R.S.

M. “Risk assumption” or “risk sharing” means a transaction whereby the chance of loss, including the expenses for the delivery of service, with respect to the health care of a person is transferred to or shared with another entity (e.g., Carrier, including an LSLPN), in return for a consideration. Examples include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity agreements. For the purposes of this regulation, fee-for-service, per diem payments, diagnostic-related group payment agreements, and employee assistance programs (EAPS) are not considered to be risk assumption or risk sharing arrangements.

N. “Risk based Capital (RBC)” is a formula which quantifies the assets, liabilities, size and risk profile of a regulated entity in order to determine the minimum amount of capital and surplus required to be maintained by a company. The RBC formula provides an elastic means of setting the capital and surplus requirement, in which the degree of risk taken by the entity is the primary determinate.

Section 4 Applicability

The provisions of this regulation apply to:

A. Entities licensed as, or required to be licensed as, a sickness and accident insurance company; a nonprofit hospital, medical-surgical, and health service corporation; or a health maintenance organization that contracts with provider networks for the delivery or provision of health care services;

B. Entities required to be licensed as a limited service licensed provider network (LSLPN)

Section 5 Licensure Options for Provider Networks Transacting the Business of Insurance

A. A provider network shall not issue any contract of insurance, including risk assumption or risk sharing agreements, nor shall it accept or assume all or part of the risk inherent in a contract issued by another entity, other than from a licensed carrier or with another entity that contracts with licensed carriers as allowed by this regulation, without first receiving a license from the commissioner.

B. Provider networks may apply to the Division of Insurance for a license to transact the business of insurance as follows:

1. A provider network may apply for licensure as a sickness and accident insurance company; a nonprofit hospital, medical-surgical, and health service corporation; or a health maintenance organization, if the provider network meets the applicable terms and conditions for such licensure. Once licensed, the provider network shall be subject to all the statutory requirements of the Insurance Code under which it was licensed.

2. A provider network may apply for licensure as an LSLPN as provided by this regulation.

    a. In order to be eligible to make such application for this license, a provider network must be legally bound and obligated to provide health care through an LSLPN as defined in Section 3 of this regulation.

    b. The provider network must agree that in the event a member of the network is not able or willing to provide services to a consumer (e.g., individual, group, employer, etc.) under contract with the network, or any of its employees, the network will be obligated to continue providing such services.

    c. The LSLPN may enter into contractual arrangements for incidental services with other entities subject to the following:

        i. The LSLPN shall only contract for health services which are incidental, but necessary to the performance of the LSLPN health coverage plans offered by the LSLPN. Payments made for these incidental services shall not exceed ten percent (10%) of total capitation fees/premiums received annually by the LSLPN.

        ii. The contract(s) for incidental service(s) shall contain a hold harmless provision as outlined in § 10-16-705(3), C.R.S.

3. A provider network that meets the definition of a health maintenance organization, or in the commissioner's opinion offers services which do not differ significantly from the basic services offered by an HMO, or that provides, either directly or through contractual or other arrangements with other hospitals and/or physicians, comprehensive or major medical services to enrollees shall not be eligible for licensure as an LSLPN.

C. The commissioner may refuse to issue an LSLPN license for which a provider or provider network has applied if, in the opinion of the commissioner, the applicant qualifies as a licensed carrier under another licensure category.

Section 6 Application for a License as an LSLPN

A. A provider network may apply for a license as an LSLPN on a form prescribed by the commissioner, if it is eligible to make such application pursuant to the provisions of Section 5.B.(2) of this regulation by filing one copy of the following:

1. An application to be licensed as a LSLPN. Such application shall clearly disclose the type of authority being requested; (e.g., a limited service license to provide home health care services, or inpatient hospital services, etc.) shall be accompanied by a non-refundable filing fee of five hundred dollars ($500.00); and shall be signed by an officer or authorized representative of the applicant. If an applicant qualifies for licensure as an LSLPN, the applicant shall receive a certificate of authority limiting its right to insure only those health services requested on its application form. If the LSLPN discontinues providing any of these limited services, its certificate of authority shall be amended to include only those services that the LSLPN has the capacity, ability and legal authority to provide.

2. A detailed summary of its proposed business plan with respect to its current business operations and its proposed plan as an LSLPN. This business plan shall include, but not be limited to, the type of service to be provided; the network's form of ownership, including the name and the percentage of ownership interest of all members; its capital structure; a quantitative measurement of its capacity to provide contracted services; a detailed description of the procedures to be established to provide protection for the consumer (i.e., grievance procedures, peer review, case utilization procedures, etc.); a description of the network's geographical service area; and an explanation of the techniques to be implemented to ensure continuity of care for all covered persons should the LSLPN incur a change in its providers, geographical area or financial solvency.

3. Biographical sketches of all proposed officers, directors, owners and organizers, and information providing confirmation of their background and experience in the management or delivery of the services to be delivered through the LSLPN. Such biographical information shall be submitted on the NAIC form (available upon request), along with a complete fingerprint set, as may be secured from local law enforcement sources which the commissioner shall forward to the Colorado Bureau of Investigation for the purpose of conducting a state and national fingerprint based criminal history record check in accordance with § 10-3-112, C.R.S. Any person who has managerial involvement or control of a company that underwent any adverse state administrative action shall include information about the adverse administrative action. Submission of the fingerprint set may be waived by the commissioner where deemed appropriate.

4. A current audit, certified by an independent certified public accountant, of its financial condition, or current financial information attested to by an officer of the LSLPN applicant. In addition, three (3) years of financial projections, including balance sheets, income statements and cash flow statements must be provided. The projections shall contain projected per member per month enrollment at fiscal year end and a concise summary of all assumptions used to generate the projections.

5. A copy of the LSLPN'S proposed LSLPN Health Coverage Plan(s), contracts, arrangements, marketing and advertising material, and a complete listing of its producers.

6. A copy of the LSLPN's organizational documents, (e.g. articles of incorporation, partnership agreements, etc.) including any contracts between providers. Copies of the forms used for all contractual arrangements with providers of incidental services are also included in this requirement. The commissioner retains the right to review and approve or disapprove the actual contractual arrangement between the LSLPN and the provider of incidental services to determine whether such arrangement is contrary to the best interests of the public.

7. A copy of any management or administrative contract(s) entered into, or to be entered into, by the LSLPN.

8. A list of the providers comprising the LSLPN'S provider network, including each provider's medical designation, field of practice or specialty, licensure category, and a description of the LSLPN'S procedures for determining on an on-going basis that each provider is duly licensed.

9. Information with regard to the measures and protections in place to ensure the financial solvency of the provider network. Such measures and protections may include business interruption insurance, stop-loss insurance, access to additional capital, etc.

10. A copy of the LSLPN'S plan to coordinate benefits with respect to workers' compensation, personal injury protection benefits, third-party recovery and subrogation rights.

11. Confirmation that the LSLPN uses standardized codes, billing processes and formats.

12. Confirmation that the applicant has the capability to satisfactorily manage the health care coverage issued. This confirmation is to include a detailed description of the LSLPN's procedures established and implemented to ensure the maintenance of all books and records necessary to meet all reporting requirements. This requirement can be met through a third party management or administration agreement.

13. Schedule of rates or charges, including all co-payments, deductibles, premiums and incidental fees. This information shall include the basis for calculation (e.g., use of usual, customary, and reasonable (UCR) costs).

14. Any other information deemed necessary by the commissioner in evaluating the application.

B. Prior to implementing any material changes in its operations, or in the coverage offered by the LSLPN, and in no less than thirty (30) days prior to the anticipated change, the LSLPN shall submit to the commissioner a written description of any material modification to its plan of operation, or a written explanation of any material changes to the information submitted in accordance with Section 6 A.

Section 7 Standards of Operation for an LSLPN

All LSLPNs shall be responsible for meeting the following standards of operation both at the time of initial licensure, in the evaluation of their application, and continuously thereafter:

A. Maintain an unqualified annual audited financial report certified by an independent certified public accountant (CPA), performed in accordance with Generally Accepted Auditing Standards (GAAS), and based upon Generally Accepted Accounting Principles (GAAP). All CPA reports must provide separate detail for income and expenses derived from:

1. Risk sharing and risk assumption arrangements between the LSLPN and licensed carriers; and

2. The LSLPN health coverage plans issued by the licensed LSLPN.

B. Demonstrate financial stability to the commissioner and maintain a minimum net worth. Minimum net worth, excluding any goodwill or other intangible assets, must be equal to the greatest of (i) one hundred thousand dollars ($100,000), (ii) 2 (two) times the authorized control level of the most recent risk based capital calculation, or (iii) such other amount as may be determined by the commissioner and commensurate with the risk assumed by the LSLPN.

C. Demonstrate its capacity to administer the health plans being offered, and its ability to achieve, monitor, and evaluate the quality and cost effectiveness of care being provided by its health care providers, and adequacy of its provider network and third-party agreements in assuring reasonable access to care. This requirement shall be met by certification by an independent reviewer and subject to acceptance by the commissioner.

D. Provide for the collection of capitation fees/premium payments from the individual, employer, or group, on a monthly basis only, unless otherwise approved by the commissioner.

E. Provide an annual certification by an executive officer of the LSLPN warranting the following:

All LSLPN health coverage plan(s), contracts or agreements or a combination thereof are not being offered and marketed as substitute for comprehensive or major medical insurance coverage.

F. Assure that all administrative and management agreements include: a provision that the contract may not restrict the LSLPN governing body from appointing, removing or changing officers or employees of the LSLPN; a clear statement of the responsibilities and ownership of all books and records, assets, liabilities and compensation under the contract, where applicable; and if the LSLPN contracts for electronic data processing (EDP) and/or management information systems (MIS), a provision providing appropriate access to the system upon examination by the commissioner, and a mechanism under which the system is available to the LSLPN or its successor upon insolvency of the LSLPN, or termination or cancellation of the contract.

G. Provide a written notice of cancellation to the commissioner within sixty (60) days prior to canceling any administrative or management agreement.

Section 8 Statutory Deposit

A. Each LSLPN shall deposit securities, acceptable to the commissioner, in an amount based on enrollment levels achieved on the last day of the LSLPN's fiscal year according to the following schedule.

1. $300,000 for enrollment of less than 60,000

2. $350,000 for enrollment of 60,000 but less than 100,000

3. $400,000 for enrollment of 100,000 or more

B. The deposit shall be in a manner provided pursuant to § 10-3-210, C R S. and Colorado Insurance Regulation 3-2-6 (3 CCR 702-3), and subject to the joint control of the commissioner for the protection of Colorado contractholders. The securities must be in marketable securities and should, at all times, be of top quality, readily marketable, and equal to the amount required.

Section 9 Fidelity Bond

The funds received from enrollees must be treated in a fiduciary capacity. In order to protect the LSLPN contractholders from misuse of contractholder funds, an LSLPN licensed in Colorado shall maintain a fidelity bond covering the officers, directors, and employees who have access to the LSLPN funds. The fidelity bond must be issued by an insurance company holding a certificate of authority in this state and meet the requirements of Colorado Insurance Regulation 3-1-1 (3CCR 702-3).

Section 10 Annual Reporting and Licensing Procedures

A. The license shall expire on June 30 each year and shall be renewed annually if the LSLPN has

continued to comply with this regulation. Every license shall automatically be extended until such time as the commissioner refuses to renew the license of such LSLPN.

B. An LSLPN shall be deemed relicensed if it is in compliance with the provisions of Sections 5.B.2, 7, 8, 9 and does all of the following:

1. Remits an annual filing fee of five hundred dollars ($500.00) by June 30.

2. Remits annually by September 1 the greater of one hundred dollars ($100.00) or an amount equivalent to five cents ($0.05) per person enrolled in the LSLPN program as of the immediately preceding fiscal year end.

3. Files an annual audited financial report: All LSLPNs shall have an annual audit by an independent certified public accountant and shall file the audited financial report with the commissioner no later than one hundred fifty (150) days following the LSLPN's fiscal year end. See Appendix A for Guidelines for Filing of Annual Audited Financial Reports.

4. The annual audited financial report shall include the amount of all capitation fees/premiums collected during the fiscal year; the amounts actually paid/allocated during such year for health care and incidental services for the covered persons; the amounts established in claim and policyholder reserve liabilities, including incurred but not yet paid/performed, unreported and unbilled cases, retroactive cost adjustments and unearned premium; all other liabilities and obligations required of such LSLPN; number of members and member months; and such other information relating to the performance of the LSLPN as is necessary to enable the commissioner to carry out his/her duties.

5. The annual audited financial report shall be accompanied by a completed Risk Based Capital report for the same period of time.

C. Any late filings shall be subject to a penalty up to one hundred dollars ($100) per day for each day late and/or shall result in suspension or revocation of the license.

D. Any other information or reports requested by the commissioner.

Section 11 Requirements of LSLPN Health Coverage Plans

A. All LSLPN health coverage plans, contracts, policies, and agreements shall be subject to all provisions of Title 10 that apply to health policies, plans, or contracts issued on a group basis as provided for in Section 15 of this regulation, except as provided herein:

1. LSLPN health coverage plans shall only be required to comply with those mandatory coverage provisions enumerated in § 10-16-104, C.R.S., that relate directly to the type of medical care or health service benefit (e.g. mental health care, hospital care, etc.) contractually provided for by the LSLPN health coverage plan as allowed by this regulation.

2. LSLPN health coverage plans shall not contain any provision which would provide coverage for a covered person for services received outside of the LSLPN.

B. All LSLPN health coverage plans shall prominently disclose on the front page of the plan the type of medical specialty benefits and/or limited health care service being provided, and shall state that the plan is being provided by an LSLPN. Such plan must clearly be labeled as a “Limited Service Licensed Provider Network Health Coverage Plan.”

C. All LSLPN health coverage plans shall prominently disclose, in large type, in any written agreement, certificate, contract, plan, or policy issued by such LSLPN the following notice:

"NOTICE"

"This health coverage plan is issued by your Limited Service Licensed Provider Network. This plan is subject to some but not to all of the insurance laws and regulations of Colorado, and is not a substitute for comprehensive or major medical coverage. Colorado insurance guaranty funds are not available for your Limited Service Licensed Provider Network Health Coverage Plan in the event of an insolvency of this plan."

Section 12 Evidence Of Coverage

A. Every contractholder/enrollee shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

1. The limited health service to which each contractholder/enrollee is entitled;

2. Any limitation of the service, kinds of service or benefits to be provided, and exclusions, including any deductible, co-payment or other charges;

3. Where, and in what manner, information is available as to where and how services may be obtained; and

4. The method for resolving complaints.

B. Any amendment to the evidence of coverage shall be provided to the subscriber in a separate document at least thirty (30) days prior to the effective date of the amendment.

Section 13 Complaint System

Pursuant to § 10-3-1104(1)(i), C.R.S. a complaint system shall be maintained by all LSLPNs. The complaint system shall include a complaint record which provides at least the minimum information as required in Colorado Insurance Regulation 6-2-1, (3 CCR 702-6).

Section 14 Filing of Policy Forms, Rates and Charges

A. Policy forms shall be certified in accordance with § 10-16-107.2, C.R.S. and Colorado Insurance Regulation 1-1-6 (3 CCR 702-1).

B. The rates and charges shall be reasonable in relation to the service provided. No schedule of charges or rates shall be used by an LSLPN unless a copy of such schedule of charges or rates, or amendments thereto, has been filed with the commissioner prior to use. Rate filings are to include an actuarial certification that the rates are not excessive, inadequate or unfairly discriminatory. Rates and premiums for products issued by an LSLPN are to be determined on a fixed prepayment basis. Therefore, no LSLPN product may be issued on a cost plus or retrospective rating basis. An LSLPN may require co-payments, co-insurance or deductible payments of enrollees as a condition for the receipt of specific health service unless otherwise prohibited by law. Such payments for service shall be shown in the contract as a specified dollar amount or percentage. An annual certification, by a qualified actuary, to the appropriateness of the charges or rates, based on reasonable assumptions, shall accompany the annual rate filing along with adequate supporting information.

Section 15 Other Provisions Applicable To LSLPNS

A. The provisions of Title 10 and appropriate regulations shall apply except as they are inconsistent or inapplicable to LSLPNs.

B. It is the duty of all LSLPNs licensed pursuant to this regulation to comply with all other applicable state and federal regulations.

Section 16 Suspension/Revocation of an LSLPN's License

An LSLPN's license may be suspended or revoked by the commissioner for failure to comply with the provisions of this regulation, or with any other applicable state regulations and statutes, or if the commissioner determines that continued licensure would be detrimental to the covered individuals, insurance buying public, or the general public of this state.

Section 17 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of Cease and Desist Orders, and/or suspensions or revocation of license.

Section 18 Severability

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

Section 19 Effective Date

This regulation is hereby effective on January 1, 2009.

Section 20 History

Originally adopted November 1, 1996.

Amended effective November 1, 2003.

Amended effective January 1, 2009.

APPENDIX A Guidelines For Filing of Annual Audited Financial Reports

1. Filing and extensions for filing of annual audited financial reports and related information

   A. All LSLPNs shall have an annual audit by an independent certified public accountant and shall file the audited financial report with the commissioner no later than one hundred fifty (150) days following the LSLPN's fiscal year end.

   B. Extensions of the filing date may be granted by the commissioner for thirty (30) day periods, upon a showing by the LSLPN and its independent certified public accountant of the reasons for requesting such extension and upon determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten (10) days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension. “Press of business” or similar reasons shall not be grounds for an extension.

2. Contents of annual audited financial report

   The annual audited financial report shall be performed in accordance with generally accepted auditing standards and the financial position of the LSLPN as of the end of the most recent fiscal year and the results of its operations, cash flows and changes in net worth for the year then

ended in conformity with generally accepted accounting principles.

The annual audited financial report shall include the following:

A. Report of independent certified public accountant;

B. Balance sheet reporting assets, liabilities and net worth;

C. Statement of operations;

D. Statement of cash flows;

E. Statement of changes in net worth;

F. Notes to financial statements. These notes shall also include a summary of ownership and relationships of the LSLPN network and all affiliated provider networks.

G. The financial statements included in the audited financial report:

i. Shall be comparative, presenting the amounts as of the current fiscal year end and the amounts as of the immediately preceding fiscal year end. However, in the first year in which an LSLPN is required to file an audited financial report, the comparative data may be omitted;

ii. Amounts may be rounded to the nearest thousand dollars ($1,000), and immaterial amounts may be combined.

3. Qualifications of independent certified public accountant

The commissioner shall not recognize as a qualified independent certified public accountant, and not accept any annual audited financial report, prepared in whole or in part by, any natural person who:

A. Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961-1968, or any dishonest conduct or practices under federal or state law;

B. Has been found to have violated the Insurance Laws of Colorado with respect to any previous reports submitted under this regulation; or

C. Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this regulation

4. Notification of adverse financial condition

The LSLPN shall require the independent certified public accountant to report, in writing within five (5) business days to the board of directors and its audit committee, any determination by the independent certified public accountant that the LSLPN has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under audit or that the LSLPN does not meet the minimum net worth requirements under this regulation as of that date. The LSLPN which has received a report pursuant to this paragraph shall forward a copy of the report to the commissioner within five (5) business days of receipt of such report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive such evidence within the required five (5) business day period, the independent certified

accountant shall furnish the commissioner a copy of its report within the next five (5) business days.

5. Report on significant deficiencies in internal controls

In addition to the annual audited financial statements, each LSLPN shall furnish the commissioner with a written report prepared by the independent certified public accountant describing significant deficiencies in the LSLPN's internal control structure noted by the accountant during the audit. No report shall be issued if the accountant does not identify significant deficiencies. If significant deficiencies are noted, the written report shall be filed annually by the LSLPN with the Division within sixty (60) days after filing the annual audited financial statements. The LSLPN is required to provide a description of remedial actions taken or proposed to correct significant deficiencies, if such actions are not described in the accountant's report.

6. Accountant's letter of qualifications

The accountant shall furnish to the LSLPN in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

A. That the accountant is independent with respect to the LSLPN and conforms to the appropriate standards of the profession, including the code of professional ethics and pronouncements of the AICPA and the rules of professional conduct of the Colorado Board of Public Accountancy, or similar code, as then might be in effect.

B. The background and experience in general, and the experience in audits of companies of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this regulation shall be construed as prohibiting the accountant from utilizing such staff as deemed appropriate where use is consistent with standards prescribed by generally accepted auditing standards.

C. That the accountant understands the annual audited financial report and the opinion thereon will be filed in compliance with this regulation and that the commissioner will be relying on this information in the monitoring and regulation of the financial positions of LSLPNS.

D. That the accountant consents and agrees to make available for review by the commissioner, or the designee or appointee of the commissioner, the workpapers as defined in Section 7. below, and that the workpapers will be retained for a period not to less than five (5) years.

E. A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA.

7. Review and retention of workpapers and documents.

Every LSLPN required to file an audited financial report pursuant to this regulation shall require the accountant to make available for review by Division examiners, upon reasonable notice and during normal business hours, all workpapers prepared in the conduct of his/her audit, including any communication related to the audit between the accountant and the LSLPN. The accountant's workpapers shall be made available at the offices of the LSLPN, at the Division or at any other reasonable place designated by the commissioner. The LSLPN shall require that the accountant retain the audit workpapers including communication documents until the Division has filed a report on examination covering the period of the audit, but not less than five (5) years from the date of the audit report.

In the conduct of an examination by the Division examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the Division. All working papers including communications obtained shall be afforded the same confidentiality as other examination workpapers generated by the Division.

Notwithstanding the above, audit reports and workpapers are additionally subject to, and protected by, the provisions of Article 2 of Title 12, C.R.S.

8. This regulation shall not prohibit, preclude or in any way limit the commissioner from ordering and/or conducting and/or performing examinations of LSLPNS under Colorado Laws and Regulations.

Regulation 2-1-10 MOTOR VEHICLE SELF-INSURANCE [Eff. 04/01/2009]

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § §10-1-109, 42-7-501, 10-4-601.5 and 42-7-201, C.R.S.

Section 2 Scope and Purpose

Section 10-4-624 C.R.S., provides that any person in whose name more than twenty-five (25) motor vehicles are registered may qualify for self-insurance. This provision affords owners of fleets of motor vehicles a cost effective method of complying with Colorado's motor vehicle financial responsibility requirements while affording coverage and protection to the general public. The purpose of this regulation is to set the filing requirements and standards for certification as a self-insurer under §10-4-624, C.R.S. It is the opinion of the Commissioner that any owner of motor vehicles which must be registered should either obtain complying motor vehicle insurance or comply with this regulation.

Section 3 Applicability

This regulation shall apply to any person that either currently has, or is seeking to obtain, a motor vehicle certificate self-insurance issued by the Colorado Division of Insurance.

Section 4 Definitions

As used in this regulation, and unless the context requires otherwise:

A. "Applicant" shall mean the person in whose name the motor vehicles to be self-insured are registered.

B. "Holding company system" means a structure whereby a parent company directly or indirectly owns or controls more than 50% of the issued and outstanding voting securities of the applicant.

C. "Registered" means a motor vehicle registered in the state of Colorado in the name of the applicant.

Section 5 Filing Requirements

A. Initial and renewal certificates of self-insurance shall be valid for one year after issuance for private entities and for three years after issuance for government entities. Initial and renewal filings shall be submitted to the Division's Corporate Affairs Section.

B. Each initial filing shall include the following:

1. Name, address, phone number of the applicant, and a description of the nature of the applicant's business. The information should include any trade names or d/b/a's of the applicant.

2. Detailed explanation of the plan of operation including administrative procedures, risk management, risk retention, reinsurance, actuarial and claims handling procedures and description of the expertise of the personnel providing actuarial and claims handling services.

3. List of motor vehicles owned by the applicant with the vehicle identification number (VIN) and registration number for each vehicle. The applicant must demonstrate that it will maintain registration of at least 25 motor vehicles throughout the certification period.

4. If the applicant intends to self-insure a motor vehicle not registered in its name, it shall cite the Colorado statute or regulation requiring it to maintain a complying policy of insurance upon said vehicle. The applicant shall affirm that it is in compliance with all provisions of said statute or regulation.

5. In the case of an applicant owned by a holding company system, a guarantee from the parent company, or an affiliate which files a consolidated financial statement with the applicant, guaranteeing to pay all claims or judgments arising from the operation of the self-insured motor vehicle.

6. Applicant's audited financial statements from its date of formation to the present, not to exceed the prior three years, or consolidated audited financial statements for the entire organization when the applicant is part of a holding company system, for the prior three years.

7. A qualified actuarial analysis and opinion estimating the reserves necessary to pay anticipated claims and costs for the next twelve months.

8. A copy of the applicant’s prior three years' claim registers which must include each incident, the date incurred, initial estimate of the claim, the date and amount of settlement, a

statement of the number of claims in litigation and the amount of said claims, investigations of claims extending more than thirty days after receipt and claim denials. Prior to approval of the initial application, the applicant shall immediately amend the application to include any material change in the number or amount of current claims.

9. An affidavit acknowledging that the provisions of §10-3-1104(1)(h), C.R.S. shall apply to the applicant.

10. A description of any reinsurance or insurance program, including a copy of any insurance contract which would be available to pay motor vehicle claims and judgments.

11. Any other information which the Commissioner deems necessary to evaluate the application.

C. Renewal applications shall be submitted at least sixty (60) days prior to the expiration of the applicant's current certificate of self-insurance. Each filing shall include the following:

1. List of motor vehicles owned by the applicant with the VIN and registration number for each vehicle. The applicant must demonstrate that it intends to operate at least 25 motor vehicles throughout the certification period.

2. The applicant's most recent audited financial statement or most recent consolidated audited financial statement if part of a holding company system.

3. A qualified actuarial analysis and opinion estimating the reserves necessary to pay anticipated claims and costs.

4. A description and copy of any amendments to any reinsurance or insurance program.

D. Within thirty (30) days of receipt of the renewal application the Commissioner will either issue a new certificate of self insurance or notify the applicant of deficiencies with the renewal application or with the applicant's future ability to pay its self insurance obligations. Depending upon the nature of the deficiency, the applicant may be given two weeks from the date of receipt of notification from the Division to correct the deficiency. Applications that are deficient and not accepted for filing will be returned to the applicant.

E. An applicant may request a waiver of the requirements to file some or all of the information to be filed with the renewal application. The request must affirm that there have been no material adverse changes in the self-insurance plan, current ratio, net worth, or motor vehicle claims history since the date of the most recent audited financial statement filed with the Division. In granting or denying an application for waiver, the Commissioner shall consider all pertinent facts and information regarding an applicant's operations and financial condition, applicant's general compliance with this regulation and any complaints received by the Division regarding an applicant's self-insurance program. A request for waiver must be made at least 90 days prior to the expiration of the current certificate of self-insurance.

Section 6 Standards

A. A certified self-insurer shall operate as if it were a licensed insurer. It shall comply with all statutes and regulations governing the prompt investigation and payment or denial of claims.

B. In determining financial responsibility, the applicant's financial status will be reviewed to determine its ability to make payments when due and its current financial soundness. The information submitted will be reviewed to determine the acceptability of underlying assumptions used in determining plan obligations. The applicant's obligations will be valued in accordance with commonly accepted actuarial practices. The applicant's assets will be valued in accordance with

generally accepted accounting principles.

C. A private entity's financial information will be reviewed to ensure that the necessary funding levels and reserves have been established for the applicant's current and future motor vehicle self-insured obligations.

D. An applicant's net worth will be determined without considering its intangible assets.

E. Private entities must demonstrate two year's profitable operations out of the most recent three (3) years.

F. In determining the amount of a surety bond allowed under §10-4-624(3), C.R.S., the Commissioner shall rely on a qualified actuarial analysis and opinion provided by the motor vehicle carrier or contract carrier by motor vehicle estimating the reserves necessary to pay anticipated claims and costs.

G. The Division shall not accept new applications for self-insurance certification utilizing cash deposits or other trusts to secure payment of self-insured obligations. Self-insurers certified as of January 31, 1998, may continue to use any existing trust or cash deposits to secure its self-insurance obligations if the Division is otherwise reasonably satisfied that the self-insurer can pay its self-insured obligations as they become due.

Section 7 Examination of Records

A. Certified self-insurers shall maintain and make the following records available to the Commissioner for inspection either at the Division, or another location acceptable to the Division, upon seven days notice:

1. Claim file for each incident.

2. A claims register which must include each incident, the date incurred, initial estimate of the claim, the date and amount of settlement, a statement of the number of claims in litigation and the amount of said claims, investigations of claims extending more than thirty days after receipt and claim denials.

3. Separate general ledger account to track claim payments.

4. A detailed listing of all claimants in rehabilitation with information regarding the estimated monthly payments.

5. A detailed listing of all structured settlements including those amounts transferred to an insurer and those retained by the applicant.

6. Subrogation claims and payments.

7. Evidence of compliance with any Colorado statute or regulation requiring the applicant to maintain a complying policy of insurance on a motor vehicle not registered in its name.

B. If an examination or renewal application reveals that a self-insurer: (1) is operating in a manner which renders it hazardous to the public; (2) misstated or misrepresented its financial condition; or, (3) is in violation of §10-3-1104(1)(h), C.R.S., the Commissioner shall provide written notice to the self-insurer of those requirements necessary to abate the condition. Failure to abate the condition in the time allowed by the Commissioner may be grounds to modify or revoke the certificate of self-insurance upon five days' notice and after a hearing pursuant to §10-4-624(2), C.R.S.

Section 8 Modifications to the Plan of Operation

A certified self-insurer may modify its plan of operation only after approval by the Commissioner. The request shall be made in writing at least thirty (30) days prior to the effective date of the modification.

Section 9 Confidentiality

Documentation requested by the Division of Insurance and submitted in compliance herewith shall generally be considered a public record under the Public Records Act, § 24-72-201 through 206, C.R.S. In the event any requested documentation is considered by the applicant to be confidential in nature, the applicant must submit the requested information under separate cover or in a sealed envelope or file clearly labeled "CONFIDENTIAL". Attached to the documents submitted under confidential cover should be an explanation of why they are to be considered confidential. Documentation so submitted, if found to be confidential in nature by the Division of Insurance, will be maintained in a separate, confidential file and will not be released to the general public for inspection or copying.

Section 10 Severability

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

Section 11 Enforcement

Noncompliance with this Regulation or any applicable statute may result, after notice and hearing pursuant to §10-4-624(2), C.R.S. in the cancellation of a self insurer's certification.

Section 12 Effective Date

This regulation shall become effective April 1, 2009.

Section 13 History

Hearing date: December 1, 1997; Effective; January 31, 1998.

Amended and Effective May 1, 2000.

Amended effective February 1, 2004.

Amended effective April 1, 2009.

Regulation 2-1-11 VIATICAL SETTLEMENTS

Section 1. Authority

This regulation is promulgated pursuant to § § 10-7-615 and 10-1-109, C.R.S.

Section 2. Background and Purpose

The purpose of this regulation is to implement the Viatical Settlements Act, part 6, article 7, title 10, C.R.S. which governs viatical settlements and licensing requirements of viatical settlement providers and protects the rights of a life insurance policyowner seeking a viatical settlement.

Section 3. Definitions

In addition to the definitions in § 10-7-602, C.R.S., the following definitions apply to this regulation:

A. "Insured" means the person covered under the policy being considered for viatication.

B. "Life expectancy" means the mean of the number of months the individual insured under the life insurance policy to be viaticated can be expected to live as utilized by the viatical settlement provider pursuant to the viatical settlement contract, considering medical records and appropriate experiential data.

C. "Patient identifying information" means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

Section 4. License Requirements

A. No person shall act on behalf of a viator or otherwise negotiate viatical settlement contracts unless the life producer is in compliance with the requirements of the Viatical Settlements Act, this regulation and applicable provisions of Colorado regulations concerning licensing and continuing education requirements.

B. No person shall operate as a viatical settlement provider unless the person is licensed pursuant to the Viatical Settlements Act and this regulation.

C. The initial application and any subsequent renewal application for a viatical settlement provider shall be accompanied by a fee as prescribed in § 10-3-207(1.5), C.R.S. If a viatical settlement provider fails to pay the renewal fee within the time prescribed, or a viatical settlement provider fails to submit the reports required in this regulation, the nonpayment or failure to submit the required reports shall result in expiration of the license. If a viatical settlement provider has, at the time of renewal, viatical settlements where the insured has not died, it shall do one of the following:

1. Renew or maintain its current license status until the earlier of the following events:

    a. The date the viatical settlement provider properly assigns, sells or otherwise transfers the viatical settlements where the insured has not died; or

    b. The date that the last insured covered by viatical settlement transaction has died.

2. Appoint, in writing, either the viatical settlement provider that entered into the viatical settlement, the producer who received commissions from the viatical settlement, if applicable, or any other viatical settlement provider or producer licensed in this state to make all inquiries to the viator, or the viator's designee, regarding health status of the insured or any other matters.

D. A viatical settlement provider shall file with the commissioner, and thereafter for as long as the license remains in effect shall keep in force, evidence of financial responsibility in the sum of not less than $100,000. This evidence shall be in the form of a surety bond issued by an insurer authorized in the State of Colorado. The bond shall not be terminated without thirty (30) days prior written notice to the licensee and the Commissioner.

Section 5. Reasonable Payments for Terminally or Chronically Ill Insureds

If an insured is terminally or chronically ill, a viatical settlement provider shall pay an amount greater than the cash surrender value or accelerated death benefit then available.

Section 6. Reporting Requirement

A. On or before March 1 of each calendar year, the licensed viatical settlement provider shall submit an annual statement on a form prescribed by the commissioner along with the fees required in § 10-3-207 (1.5), C.R.S.

B. A life producer shall file a notice of intent to transact viatical settlement business with the Division no later than thirty (30) days after the date the producer first negotiates a viatical settlement on behalf of a viator. The notice shall be filed regardless of whether the viatical settlement contract is consummated. The notice of intent shall be on a form prescribed by the Commissioner, and shall be accompanied by a fee of $30.00. No additional notices of intent to transact viatical settlement business are required.

Section 7. General Rules

A. With respect to policies containing a provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the viator prior to entering into the viatical settlement contract, or to such other beneficiary, other than the viatical settlement provider, as the viator may thereafter designate, or in the absence of a beneficiary, to the estate of the viator.

B. Payment of the proceeds of a viatical settlement pursuant to § 10-7-609, C.R.S shall be by means of wire transfer to an account designated by the viator or by certified check or cashier's check.

C. Payment of the proceeds to the viator pursuant to a viatical settlement shall be made in a lump sum except where the viatical settlement provider has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank, or an affiliate of either. Retention of a portion of the proceeds not disclosed or described in the viatical settlement contract by the viatical settlement provider or escrow agent is not permissible without written consent of the viator.

D. A viatical settlement provider or life producer negotiating viatical settlements shall not discriminate in the making or soliciting of viatical settlements as provided by § 10-3-1104, C.R.S, or discriminate between viators with dependents and without.

E. A viatical settlement provider or life producer negotiating viatical settlements shall not pay or offer to pay any finder's fee, commission or other compensation to any insured's physician, or to an attorney, accountant or other person providing medical, legal or financial planning services to the viator, or to any other person acting as an agent of the viator.

F. A viatical settlement provider or life producer negotiating viatical settlements shall not knowingly solicit purchasers who have treated or have been asked to treat the illness of the insured whose coverage would be the subject of the investment.

G. If a viatical settlement provider enters into a viatical settlement that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain the following provisions:

1. A provision that the viatical settlement provider will effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated. Benefits in excess of the amount viaticated shall be paid directly to the viator's beneficiary by the insurance company;

2. A provision that the viatical settlement provider will, upon acknowledgment of the perfection of the transfer, either;

   a. Advise the insured, in writing, that the insurance company has confirmed the viator's interest in the policy; or

   b. Send a copy of the instrument sent from the insurance company to the viatical settlement provider that acknowledges the viator's interest in the policy; and

3. A provision that apportions the premiums to be paid by the viatical settlement provider and the viator, provided that the contract provides premium payment terms and nonforfeiture options no less favorable, on a proportional basis, than those included in the policy.

H. In all cases where the insured is a minor child, disclosures to and permission of a parent or legal guardian satisfy the requirements of the Viatical Settlements Act and this regulation.

Section 8. Prohibited Practices

A. A viatical settlement provider or life producer negotiating viatical settlements shall obtain from a person that is provided with patient identifying information a signed affirmation that the person or entity will not further divulge the information without procuring the express, written consent of the insured for the disclosure. Notwithstanding the foregoing, if a viatical settlement provider or life producer negotiating viatical settlements is served with a subpoena and, therefore, compelled to produce records containing patient identifying information, it shall notify the viator and the insured in writing at their last known addresses within five (5) business days after receiving notice of the subpoena.

B. A viatical settlement provider shall not act also as a life producer negotiating viatical settlements, whether entitled to collect a fee directly or indirectly, in the same viatical settlement.

C. A life producer negotiating viatical settlements shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

Section 9. Insurance Company Practices

A. Life insurance companies authorized to do business in this state shall respond to a request for verification of coverage from a viatical settlement provider or a life producer authorized to write viatical settlement contracts within thirty (30) calendar days of the date a request is received, subject to the following conditions:

1. A current authorization consistent with applicable law, signed by the policy owner or certificateholder, accompanies the request;

2. In the case of an individual policy or group insurance coverage where details with respect to the certificate holder's coverage are maintained by the insurer, submission of a form substantially similar to one prescribed by the commissioner, which has been completed by the viatical settlement provider or the life producer negotiating viatical settlement contracts in accordance with the instructions on the form.

B. Nothing in this section shall prohibit a life insurance company and a viatical settlement provider or a life producer negotiating viatical settlement contracts from using another verification of coverage form that has been mutually agreed upon in writing in advance of submission of the request.

C. A life insurance company may not charge a fee for responding to a request for information from a viatical settlement provider or life producer negotiating viatical settlement contracts in compliance with this section in excess of any usual and customary charges to contract holders, certificate holders or insureds for similar services.

D. The life insurance company may send an acknowledgment of receipt of the request for verification of coverage to the policy owner or certificate holder and, where the policy owner or certificate owner is other than the insured, to the insured. The acknowledgment may contain a general description of any accelerated death benefit that is available under a provision of or rider to the life insurance contract.

E. A life insurance company shall not require the viator or insured to sign any request for change in a policy or a group certificate from a viatical settlement provider that is the owner or assignee of the insured's insurance coverage, unless the viator or insured has ownership, assignment or irrevocable beneficiary rights under the policy. In such a situation, the viatical settlement provider shall provide timely notice to the insured that a settlement transaction on the policy has occurred. Timely notice shall be provided within fifteen (15) calendar days of the change in a policy or group certificate.

Section 10. Severability

If the provisions of this regulation or the application to any person or circumstances are for any reason held to be invalid, the remainder of regulation shall not be affected.

Section 11. Enforcement

Noncompliance with this Regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in § 10-3-1108, C.R.S. may be applied.

Section 12. Effective Date

This regulation shall become effective on March 1, 2006.

Section 13. History

Replaces Emergency Regulation 05-E-6 in its entirety.

REGULATION 2-2-1 CONCERNING PUBLIC ENTITY SELF-INSURANCE POOLS

I. AUTHORITY

This regulation is promulgated under the authority of § 10-1-109, Colorado Revised Statutes (C.R.S.).

II. PURPOSE

The purpose of this regulation is clarify the requirements for the formation and operation of public entity self-insurance pools. The purpose of section XII is to permit the discounting of loss reserves and to establish certain parameters so as to maintain the financial solvency and integrity of the pool. The requirements established by this regulation are hereby declared to be necessary and appropriate, and in the public interest.

III. DEFINITIONS

A. "Admitted Assets" means investments authorized for pools pursuant to Parts 6 and 7 of Article 75 of Title 24, C.R.S. and § § 8-44-204 (9), 24-10-115.5 (8), and 29-13-102 (6), C.R.S.; cash; demand deposits in solvent banks and trust companies; interest, dividends, and other income due and accrued which are not more than ninety days delinquent; uncollected contributions which are less than ninety days past due; receivables from solvent insurance companies licensed to transact business in the State of Colorado or otherwise approved as qualified non-admitted reinsurers or approved surplus lines carriers; electronic or mechanical equipment constituting a data processing or accounting system, subject to the limitations of § 10-1-102 (1) (p), C.R.S.; and other assets deemed by the Commissioner to be available for the payment of losses and claims, at values acceptable to the Commissioner.

B. "Impaired" means a pool's surplus is less than required pursuant to this regulation.

C. "Insolvent" means a pool's admitted assets are less than all of its liabilities.

D. "Member" means an entity which participates in a self-insurance pool.

E. "Public entity" means an entity authorized by § § 29-13-102, 24-10-115.5, or 8-44-204, C.R.S, to form a self-insurance pool.

F. "Self-insurance pool" or "pool" mean a pool formed by public entities pursuant to § § 29-13-102, 24-10-115.5, or 8-44-204, C.R.S.

G. "Surplus" means that amount which remains after subtracting the pool's liabilities from its admitted assets.

IV. FORMATION OF SELF-INSURANCE POOLS

For every self-insurance pool, organized after the effective date of this regulation, there shall be submitted to the Commissioner a written proposal of the pool's plan of operation which shall include the following:

A. A narrative which shall include a description of the self-insurance pool's plan of operation, which shall describe the facilities to manage the pool, administration and claims servicing, description of the duties and responsibilities of any management provider, types of coverages and applicable limits, proposed evidence of coverage certificates (policies), underwriting rules, loss reserving

procedures, claims adjusting procedures, a list of proposed membership, and proposed excess or reinsurance coverages. If the self insurance pool proposes to provide worker's compensation insurance, the narrative shall also describe how the public entities are provided the insurance coverage required by Article 44 of Title 8, C.R.S.

B. For each contract service provider referenced in the application, a detailed description of the expertise and qualifications of these providers, including the expertise and qualifications of their personnel must be submitted.

C. A feasibility study projecting future loss experience and contribution levels required to fund minimum surplus and initial operations as determined by a qualified actuary. The study shall include:

1. The underlying methods and assumptions used;

2. A summary of available loss history;

3. Any financial projections which have been prepared.

D. Method, plan and timing of capitalization.

E. Proposed intergovernmental agreement which shall comply with § § 29-1-201 through 29-1-203, C.R.S. and shall include as a minimum the provisions of Article VII contained herein.

F. Proposed structure and limits of reinsurance agreements or excess of loss policies, if any reinsurance agreement or excess of loss policy is proposed to be obtained, and evidence of coverage in the form of a binder, placement slip, letter of intent or other document indicating the coverage intended, properly executed and authorized.

G. Proposed management, claims management, investment, custodial, and safekeeping agreements, where appropriate. Other agreements shall be made available at the request of the Commissioner.

H. Proposed fidelity bond and other proposed coverages if applicable.

I. Completed application for certificate of authority accompanied by an application processing fee of one thousand five hundred dollars ($1,500), which shall represent the cost of review and processing of the proposal including the cost of any organizational examination.

J. Additional information as necessary pursuant to § § 29-13-102(3), 24-10-115.5(3), or 8-44-204(5), C.R.S. to determine whether or not proper insurance techniques and procedures will be followed.

Subsequent to the issuance of the pool's certificate of authority, the pool has 90 days to submit executed copies of those items in E, F, G and H above.

V. CONTINUED OPERATIONS OF SELF INSURANCE POOLS

A written description of any modification to the plan of operation which affects the pool's self insurance retained risk by more than 25%, and any modification of the method of funding or method of determining loss reserves, must be filed with the Commissioner. Any such modification shall be deemed approved unless the Commissioner disapproves such filing, in writing, within 30 days from the date of submission.

VI. INVESTMENTS

A. Any investment whereby the underlying instrument is not in the custody of the pool shall be subject to a custodial and safekeeping agreement meeting the following requirements:

1. The custodian must be a bank with a safekeeping or a trust department and legally qualified to act as a fiduciary.

2. Registered investments must be in the name of the pool, the name of the custodian's nominee, the name of the pool's own nominee, or other entity filed with and approved by the Commissioner, or must otherwise reflect the interest of the pool in the investments.

3. After safe delivery of securities to the bank and until redelivery or other disposition of the securities pursuant to instructions of the pool, the bank assumes liability for loss thereof due to negligence or malfeasance of the bank, its agents, officers or employees, and for mysterious or unexplained disappearance of same. Safe delivery must be evidenced by a receipt signed by any trust officer of the bank.

4. The securities of the pool in its account shall be kept separate and apart from other securities and in the case of book entry securities be separately identified from other securities; and shall at all times be available for inspection by the pool's auditor and any regulatory officials, and the bank shall cooperate with the pool's auditor in making any audit which requires inspection and verification of all said securities and property.

B. Pool investments shall be those permitted pursuant to Parts 6 and 7 of Article 75 of Title 24, and § § 8-44-204(9), 24-10-115.5(8), and 29-13-102(6), C.R.S.

C. Investments through banks shall be fully insured or protected pursuant to the provisions of the Public Deposit Protection Act, Article 10.5 of Title 11, C.R.S.

VII. INTERGOVERNMENTAL AGREEMENT

The intergovernmental agreement shall include at least the following:

A. Provisions for the election or appointment of a board of directors and their powers and duties.

B. Provisions for the election of officers and their powers and duties.

C. Requirements and provisions for regular and special meetings of the board of directors and, if all members are not represented on the board of directors, provisions specifically allowing membership to call special meetings without approval of the board of directors or officers.

D. Provisions regarding membership.

E. Provisions regarding expulsion or withdrawal of pool members including provisions to handle obligations associated with such members.

F. Procedures for the dissolution of the pool, including a requirement that the pool provide the Commissioner at least ninety (90) days advance notice of dissolution and that no dissolution shall take effect until the Commissioner approves the plan of dissolution, which shall include a methodology for addressing all debts and obligations of the pool.

G. Provisions regarding the payment of contributions by membership.

H. Provisions that any distribution of surplus or excess earnings of the pool shall not cause the pool to become impaired or insolvent.

I. Provisions that permit assessments of members in such amounts and at such times as necessary to ensure the solvency and avoid impairment of the pool.

VIII. SURPLUS LEVELS

A. The minimum surplus levels for each coverage of a self-insurance pool shall be established and maintained at the following levels. Where the pool enters into multiple types of coverage listed below, the minimum surplus shall be the combined total of the individual minimum surplus levels.

Type of Coverage	Minimum Surplus
Property	$100,000
Casualty	$200,000
Workers' Compensation	$200,000

Such minimum surplus shall be accumulated and in place within ninety (90) days from the pool's first acceptance of risk.

B. The initial minimum surplus levels of a pool may be met by the use of subordinated debt meeting the conditions and requirements of § 10-3-239, C.R.S.

C. A higher amount of minimum surplus may be required to begin and to continue operations if the Commissioner can determine that the type and size of risk being insured, the level of contributions, the size of the asset base, the existence of assessment authority, the geographical locations of insured risks, the nature and quality of the reinsurance structure, the quality, diversification and liquidity of the pool's investments, the financial status of the pool's members, or other relevant factors justify additional surplus.

IX. CERTIFICATE OF AUTHORITY

A. The Commissioner shall issue a certificate of authority to a pool after finding that proper insurance techniques and procedures are included in the written proposal submitted pursuant to this regulation.

The Division shall respond to all written proposals submitted within thirty (30) days of submission. The Commissioner shall notify the pool in writing if it is found that proper insurance techniques and procedures are not demonstrated in the submission and shall identify all deficiencies therein.

B. The Commissioner may revoke or suspend the Certificate of Authority of a pool if the Commissioner finds that revocation or suspension is in the best interest of the public and that the pool is insolvent. The Commissioner may approve a plan of abatement submitted by the pool as an alternative to such revocation or suspension.

The Commissioner may require a pool which is impaired to prepare, subject to approval of the Commissioner, a plan of abatement. Failure of an impaired pool to prepare a plan of abatement when required by the Commissioner, or to implement an approved plan of abatement, shall be grounds for revocation or suspension of the pool's Certificate of Authority.

No proceeding to revoke or suspend a pool's Certificate of Authority shall be initiated until the Commissioner has given the pool notice, in writing, of facts or conduct that may warrant such action; afforded the pool opportunity to submit written data, views, and arguments with respect to such facts or conduct; and, except in cases of deliberate and willful violation, given the pool a reasonable opportunity to comply with all lawful requirements.

Any proceeding to revoke or suspend a pool's Certificate of Authority shall comply with the State Administrative Procedure Act, Article 4 of Title 24, C.R.S.

X. JOINT DEPOSIT

Cash or securities representing the minimum surplus established by this regulation, shall be deposited with the Commissioner in a manner provided by § 10-3-210, C.R.S. Such securities shall be admitted assets which shall at all times have a market value at least equal to the minimum surplus required.

XI. FILINGS

A. Each pool shall prepare and file with the Commissioner, by March 30 of each year, an annual report which reflects the operations of the pool. The report shall be in such form as included in Appendix A herein.

B. Each pool shall file with the Commissioner an itemized annual statement of market value of securities on joint deposit before March 30 of each year. This statement shall be filed in accordance with the format identified in section III of Regulation 3-1-2, 3 CCR 702-3, pg 3 (5/92).

C. Within seven (7) months following the end of the pool's fiscal year, each pool shall file with the Commissioner a CPA audited financial report as required under § 29-1-603(4), C.R.S. Such report shall be prepared on a statutory basis.

D. Each pool shall cause to be made an actuarial report by a qualified actuary analyzing the loss funding methodology and the adequacy of the pool's loss reserves. Such report shall describe loss funding levels sufficient to pay obligations, the pure risk rate used to determine such levels, and shall recommend loss reserves and loss adjustment expense reserves sufficient to maintain minimum statutory surplus.

1. The actuarial report shall be conducted by a qualified actuary pursuant to Colorado Insurance Regulation 1-1-1, 3 CCR 702-1, pg 1 (5/92).

2. The contents of the report shall set forth the underlying methods and assumptions used.

3. The report shall be prepared annually to coincide with fiscal year end financial reporting requirements set forth in this section and shall be filed with the audit report identified in Part C of this section.

4. The pool may request a waiver of the annual actuarial report. Such request shall explain the reason and basis for waiver and be submitted to the Commissioner four months prior to the pool's fiscal year end. A letter from a qualified actuary which justifies the waiver may be required.

5. If the pool does not use the recommended loss reserve figures of the qualified actuary the pool shall attach an explanation of what figures were used and how and why they were modified.

E. The fiscal year for all above noted annual reporting of the pool may differ from a calendar year basis only with prior written approval of the Commissioner. In all cases the audit report and actuarial report must be as of the same evaluation date.

XII. DISCOUNTING OF LOSS RESERVES

A public entity self insurance pool may request authorization to discount loss reserves. Such request shall be submitted at least 60 days prior to the requested date of implementation.

A. Loss reserve discounting shall be permitted only for lines or types of insurance which justify consideration of the time value of money held in reserves for subsequent claim payments. These lines are defined to be those which have an expected payout period extending beyond three years with no more than 75% of the expected payout within the first two years, or fixed or certain

payment dates. Additionally, the applicant shall comply with the following:

1. Define and justify the interest rate assumptions used for discounting. This rate shall not exceed the lesser of (i) the company's actual 36 month average net investment yield and (ii) the current valuation rate used for life polices of duration greater than 10 years but not more than 20 years.

2. Provide an explanation of the basis and methodology upon which reserves are calculated.

3. Present a summary of all relevant loss and loss reserve history to demonstrate the appropriateness of past and current reserve practices.

4. The reserves established, together with available surplus, shall be sufficient to provide, in the actuary's opinion, a 95% confidence that funds are available to pay claims.

5. The reserves established shall take into consideration the timing of the cash flows of all assets and liabilities of the applicant. In valuing this standard, any receivable or investment in affiliated entities or persons shall not be considered, unless the actuary states in his required written opinion that the funds will be available.

All elements outlined in the preceding numbered paragraphs must be supported by and accompanied with a formal report and written opinion of a qualified actuary.

B. The Commissioner, in his discretion, may authorize loss reserves to be discounted pursuant to the applicant's request, or may modify the request in any way he sees fit, based on the justification submitted to support the standards contained in this section and any additional terms, or conditions imposed by the Commissioner. Requests shall be considered on a case-by-case basis. Approval may be granted to the applicant for specified lines of business. Approval may be subsequently withdrawn in whole or in part, in the event there is any material change in the acceptability of the assumptions or the experience shows that continued loss reserve discounting fails to satisfy the standards of this section.

C. If approval is given, the company will be required to file an actuarial report and opinion prepared by a qualified actuary annually. This report shall be of sufficient detail to verify that the above stated standards continue to be met and shall be accompanied by an opinion so stating such compliance.

XIII. RECORDS

To facilitate examination of each pool as required by law:

A. A complete set of accounting records shall be maintained by each pool for each year of operation, which shall accurately disclose the nature and detail of all accounting transactions. Such records shall at a minimum include a general ledger, a cash receipts journal and a cash disbursements journal.

B. An accurate and detailed written record of investment transactions shall be maintained by the pool. The board of directors may delegate the general investment duties to a committee, an individual or investment management service; however, the Board must review and, at least semiannually, ratify such investment transactions.

C. Each pool shall maintain a complaint register in the format and with the content described in Colorado Insurance Regulation 6-2-1, 3 CCR 702-6, pg 6 (5/92).

D. Each pool shall maintain minutes of meetings of the members, the board of directors and

committees.

E. Each pool shall maintain a separate claim file for each claim. Information on claims incurred after the effective date of this regulation shall be maintained to include, as a minimum, claim payments by line of business, claim number, claimant's name, date incurred, date reported, date paid, and the amount of each payment (including allocated loss adjustment expenses), and shall at the Commissioner's direction be summarized and filed in a hard copy form prescribed by the Commissioner or by a mutually acceptable electronic transfer means.

F. Claim files must be maintained for at least five years. The original file or a micro film form is acceptable. A historical summary of reserve transactions and payments must be incorporated into each file unless this information is maintained electronically in a form which is readily accessible and verifiable to the underlying data.

XIV. REINSURANCE AND CREDIT FOR RESERVES ON CEDED RISKS

A. Any reinsurance agreement must meet the requirements as set forth in § 10-3-118, C.R.S., and Colorado Insurance Regulation 3-3-2, 3 CCR 702-3, pg 43 (5/92).

B. Credit for reserves on ceded risks may only be taken if the conditions as set forth in § 10-3-118, C.R.S. are satisfied.

XV. EVIDENCE OF COVERAGE

Each member of a pool shall be issued a document specifically identifying the pool's direct coverage obligation.

Pools providing Workers' Compensation Insurance shall be administratively and ultimately financially responsible to see that the underlying insured is provided coverage to statutory limits. The insured at all times shall seek settlement for workers' compensation coverage from the pool, and the pool shall ensure that there exists no interruption in coverage to its members.

XVI. EXAMINATIONS

A. The Commissioner shall cause to be made an annual examination of each pool which shall include determining whether or not proper underwriting techniques, sound funding, loss reserving, and claims processing procedures are being followed. For such purposes, the Commissioner, or any person authorized by him, shall have access to all books, papers and documents of the pool, except to the extent that a conflict of interest exists in claims which involve the State of Colorado. Such examinations may consist of either an on-site examination or a desk audit based on the financial filings, actuarial reports and other information filed with the Commissioner.

B. An annual examination fee in the total amount of $1,000 which shall represent the cost of conducting the division examination shall be paid by the pool by March 30 of each year.

XVII. FIDELITY COVERAGE

A. Each pool shall obtain fidelity coverage in accordance with Colorado Insurance Regulation 3-1-1, 3 CCR 702-3, pg 1 (5/92).

B. Unless waived by the Commissioner, self-insurance pools shall require that contract service providers which handle or have access to pool funds obtain fidelity coverage.

XVIII. TRANSITION PERIOD

Pools authorized prior to the effective date of this Regulation, failing to meet the specific requirements contained in this Regulation, shall comply within 180 days. In the event the pool is unable to comply within this period it shall file a notice with the Commissioner which sets forth, for approval, a plan of compliance. Upon review by the Commissioner and concurrence with the plan, an additional period of time may be granted by the Commissioner to comply with this Regulation.

XIX. CONFIDENTIALITY

Documentation requested by the Division of Insurance and submitted in compliance herewith, shall generally be considered a public record under the Public Records Act, § § 24-72-201 through 206, C.R.S.

In the event any requested documentation is considered by the pool to be confidential in nature, the pool must submit the requested information under separate cover or in a sealed envelope or file clearly labeled "CONFIDENTIAL" . Attached to the documents submitted under confidential cover should be a brief, typed explanation of why they are to be considered confidential.

Documentation so submitted, if found to be confidential in nature by the Division of Insurance, will be maintained in a separate, confidential file and will not be released to the general public for inspection or copying.

XX. SEVERABILITY

If any provision of this Regulation is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or unenforceability shall not affect the other provisions, and this regulation is expressly declared to be severable.

XXI. EFFECTIVE DATE

This regulation is hereby amended and restated and shall be effective on December 1, 1992.

APPENDIX A

NAME OF POOL _____

DATE OF STATEMENT December 31, _____ or, Fiscal Year Ended._____

A STATEMENT OF ASSETS, LIABILITIES AND SURPLUS

Assets:		
Invested securities	_____	
Cash	_____	
Uncollected contributions	_____	
Other uncollected assessments	_____	
Other Admitted assets	_____	
Total Assets		_____
Liabilities:		

Loss reserves	_____	
Loss adjustment expense reserves	_____	
Unearned contributions	_____	
Other expenses	_____	
Other liabilities	_____	
Total Liabilities		_____
Surplus:		
Subordinated debt.	_____	
Contributed surplus	_____	
Unassigned surplus	_____	
Total Surplus		_____

B) STATEMENT OF INCOME

Revenue:		
Contributions and assessments earned	_____	
Investment income	_____	
Other income	_____	
Total Income		_____
Expenses :		
Losses incurred	_____	
Loss adjustment expenses incurred	_____	
Other underwriting expenses	_____	
Total Expenses	_____	
Net Income (Loss)		_____

COVERAGE(S) PROVIDED

Number of members

_____

_____

Type & character of coverage(s) _____

_____

_____

_____

_____

_____

Attach a schedule to be included with this report which details any reinsurance credit/debit incorporated herein and the name of each such carrier.

This report is sworn to be a true and correct statement of the condition of the above named pool.

_____ Chief Executive Officer (signature)

_____ Chief Executive Officer (typed)

REGULATION 2-2-2 CONCERNING EMPLOYERS WORKERS' COMPENSATION SELF-INSURANCE POOLS

I. AUTHORITY

This regulation is promulgated under the authority of § 8-44-205(9), Colorado Revised Statutes (C.R.S.).

II. PURPOSE

The purpose of this regulation is to clarify the requirements for the formation and operation of employer's self-insurance pools. The requirements established by this regulation are hereby declared to be necessary, appropriate and in the public interest.

III. DEFINITIONS

As used in this regulation, unless the context otherwise requires:

A. "Admitted Assets" means the securities set forth in section XIV of this regulation and interest earned thereon, but shall also include membership claim deductibles as specifically permitted by the workers' compensation laws of the State of Colorado to the extent that the aggregate receivable for such deductibles does not exceed one percent (1%) of admitted assets and such receivable amounts have not been been accrued for more than ninety days from the date the claim was paid; uncollected premium contributions which are less that ninety days past the effective date of coverage; and recoverables from solvent insurance companies licensed in the State of Colorado or otherwise approved as qualified non-admitted reinsurers.

B. "Board of Directors" means the governing body of the pool consisting of at least five (5) directors.

C. "Deductible" is the amount indicated on the declarations page as per requirements in Articles 40 to 47 of Title 8, C.R.S, the existence of which shall not affect the requirement of an employer to

report an injury or death to the division as required in § 8-43-103(1), C.R.S.

D. "Employers" means a bona fide trade or professional association or two or more employers which are engaged in the same or similar type of business or are members of the same bona fide trade or professional organization.

E. "Expected level of funding" means the level of funding as determined by a qualified actuary which provides for expected indemnity and medical losses, expected loss adjustment expenses (allocated) which shall include ample margin for adverse experience as may be recommended by the qualified actuary.

F. "Impaired" means when a pool's surplus is less than required pursuant to this regulation.

G. "Insolvent" means when a pool's admitted assets are less than all of its liabilities or if it is unable to pay its obligations.

H. "Member" or "Members" mean an employer which has joined the self insurance pool.

I. "Pool Agreement" means the agreement in which the governing articles of the pool are set forth.

J. "Proposal" means the description of the pool's plan of operation submitted to the Commissioner which shall include fully executed documents and agreements as identified in section IV of this regulation.

K. "Qualified Actuary" is defined in Regulation 1-1-1, 3 CCR 702-1, pg 1 (5/92).

L. "Self-Insurance pool" or "pool" mean a pool formed by employers pursuant to § 8-44-205, C.R.S.

M. "Surplus" means that amount which remains after subtracting the pool's liabilities from its admitted assets. Subordinated debt referred to in section VII of this regulation, shall not be deemed a liability until repayment of principal and/or interest has been approved by the Commissioner.

N. "Trust Fund" or "Premium Fund" is the pool's retention under the terms of an aggregate excess insurance contract, or if no aggregate excess coverage is provided, the expected level of funding established to pay workers' compensation claims as determined by a qualified actuary.

IV. FORMATION OF SELF INSURANCE POOLS

For every self-insurance pool formed there shall be submitted to the Commissioner a written proposal of the pool's plan of operations which shall include the following:

A. A detailed description of the self-insurance pool's plan of operations which shall include at a minimum: (1) facilities to manage the pool, (2) administration and claims servicing arrangements, (3) custodial and investment management services, (4) types of coverages and applicable limits, (5) reinsurance structure, (6) underwriting rules and procedures, (7) medical treatment plan, (8) safety and loss control plan, and (9) qualifications and standards of membership.

B. A feasibility study prepared by a qualified actuary projecting future loss experience and premium levels required to fund minimum surplus and initial operations.

C. Executed pooling agreement which shall comply with § 8-44-205, C.R.S. and this regulation.

D. Five-year financial projection of the pool's operations.

E. Specimen of proposed reinsurance agreements and evidence of coverage in the form of binder,

placement slip or other document properly executed and authorized.

F. Fidelity bond.

G. Completed application for certificate of authority accompanied by an application processing fee of one thousand five hundred dollars ($1,500), which shall represent the cost of review and processing of the proposal including the organizational examination.

H. Composition of the pool's board of directors, officers and principal employees including biographical affidavits for all such persons.

I. Conflict of interest policy and executed conflict of interest statements.

J. Investment policy and guidelines which define investment authority.

K. Custodial, investment, and safekeeping agreement(s), which shall conform to Colorado regulations.

L. Executed management, claims management, investment, custodial, and safekeeping agreements. Other agreements shall be made available at the request of the Commissioner.

For each contract service provider referenced in the application, a detailed description of the expertise and qualifications of these providers including the expertise and qualifications of their personnel must be submitted.

M. Additional information as necessary pursuant to § 8-44-205, C.R.S., to determine whether or not proper insurance techniques and procedures will be followed.

V. CONTINUED OPERATIONS OF SELF INSURANCE POOLS

A written description of any significant modifications to the plan of operation licensed by the Commissioner must be filed and approved before implementation. Areas which are deemed to be significant include, but are not necessarily limited to the following:

A. Changes in retained risk if the risk increases by more than 25%.

B. Changes in funding methodology which must be accompanied by a certification from a qualified actuary.

Failure to submit modifications shall be grounds for revocation or suspension of a pool's certificate of authority pursuant to § § 8-44-205, (7)(a)(VI) and (VII); or supervision or rehabilitation pursuant to § § 8-44-205, (8)(d) and (e), C.R.S. Any such modification shall be deemed approved unless the Commissioner disapproves such filings in writing within 30 days from the date of submission.

VI. POOL AGREEMENT

This agreement must jointly and severally bind each member to pay claims and comply with all provisions of the workers' compensation laws of the State of Colorado. In addition, this agreement must also specifically set forth the following:

A. Provisions for the election or appointment of a board of directors and their powers and duties.

B. Provisions for the election of officers and their powers and duties.

C. Requirements and provisions for meetings of the membership and the board of directors.

D. Criteria for membership in the pool which may include time in business, net worth, business experience, acceptance of risk management/loss control standards or cost containment procedures.

E. Provisions for the withdrawal or expulsion of pool members.

F. Provisions for the dissolution of the pool per section XVII.

G. Provisions for the payment of annual and periodic premium contributions, and the payment of initial surplus contributions as applicable. Such premium contributions shall at least equal, in the aggregate, 100% of the expected level of funding of the retained risk, net of reinsurance.

H. Provisions for the distribution of surplus or excess earnings so as not to cause the pool to become impaired or insolvent.

I. Provisions for the assessment of members in such amounts and at such times as necessary to insure the solvency, continued operation and avoid impairment of the pool. This will include financial standards for membership and standards for securing unpaid assessments of withdrawn members.

1. Should a member not have the financial resources to pay an assessment, the remaining members may be assessed as required to fund all reserve liabilities.

2. Any member which withdraws from the pool must remain liable for any outstanding assessments or future assessments made by the pool for incurred obligations. Any unpaid assessments due from a withdrawing member must be secured by that member. Such security must qualify as admitted asset and be assigned to the pool.

J. Specifically define insolvency and impairment as set forth in section III of this regulation.

K. Other provisions as applicable and as deemed necessary.

VII. MINIMUM SURPLUS LEVELS AND FINANCIAL REQUIREMENTS

A. The minimum surplus level shall be the greater of:

1. $400,000,

2. One-third of the annual net written premiums, or

3. Two times the pool's specific per occurrence retention.

B. A higher amount of minimum surplus may be established to begin and continue operations if the Commissioner determines that the type and size of risk being insured; the level of contributions; the size of the asset base; the existence of assessment authority; the geographical locations of insured risks; the nature and quality of the reinsurance structure; the quality, diversification and liquidity of the pool's investments; the financial status of the pool's members; or other relevant factors justify additional funding. The minimum surplus level shall be accumulated and in place before acceptance of any risk.

C. The initial capitalization of a pool may be held in the form of cash, acceptable securities or one or more subordinated debentures which shall conform to the provisions of § 10-3-239, C.R.S.

D. The pool must have combined annual net premiums of at least $500,000. For the initial policy year of operation, such premium contributions must be in place before coverage is provided. For

succeeding policy years, a deposit premium of at least 40% of the estimated annual premium must be made upon binding coverage.

VIII. SECURITY DEPOSIT

A. Acceptable securities representing the minimum surplus established by this regulation shall be deposited with the Commissioner in the manner provided by § 10-3-210, C.R.S., and shall comprise only admitted assets of the pool as described below, which shall at all times have a market value at least equal to the minimum surplus required.

In addition to cash, deposit funds acceptable to the Commissioner shall be U. S. Government bonds, notes or bills issued or guaranteed by the United States of America and certificates of deposit issued by solvent commercial banks or savings and loan associations which are fully insured as to principal and interest by the Federal Savings and Loan Insurance Association, Federal Deposit Insurance Corporation or other government sponsored insurance program, and such other investments as are approved by the Commissioner.

B. Such deposit shall be established before the pool is permitted to bind coverage.

C. Pools shall file annually with the Commissioner an itemized statement of market value of securities on deposit. This statement shall be filed in accordance with the provisions of section III of Regulation 3-1-2, 3 CCR 702-3, pg 3 (5/92).

IX. SECURITY STANDARDS

A. All self insurance pools shall provide coverage to statutory limits and annually establish a trust fund to provide payment of the total workers' compensation loss costs incurred by membership. The trust fund shall equal or exceed the expected level of funding as determined by a qualified actuary.

B. The pool is permitted to engage in reinsurance transactions for the purpose of limiting the exposure and risk of the pool.

C. For each policy year premium contributions from membership shall be charged so as to maintain the trust fund being equal to the recommended total expected level of funding of the retained risk, net of reinsurance, as determined by a qualified actuary, plus the additional funds sufficient to pay reinsurance costs and the administrative costs of the pool.

X. ISSUANCE OF CERTIFICATE OF AUTHORITY

A. The Commissioner shall issue a certificate of authority to a pool after finding that proper insurance techniques and procedures included in the written proposal submitted pursuant to sections IV, VII and VIII of this regulation are acceptable.

B. Costs of the review of the submission incurred by the Commissioner shall be paid by the pool as stated in section IV.G.

XI. EXAMINATIONS

A. Prior to licensure, the Commissioner may conduct an organizational examination to verify that the pool has been established in accordance with the submission of the written proposal to form the pool.

B. In addition to the organizational examination, the Commissioner shall conduct an examination of each pool as required by law, which efforts shall include determining whether or not proper

underwriting techniques and sound funding, loss reserving and claims processing procedures are being followed. For such purposes, the Commissioner, or any person authorized by him, shall have access to all books and records, papers and documents of the pool. Such examinations may consist of either an on-site examination or desk audit based on the financial filings, actuarial reports and other information filed with the Commissioner.

C. Costs of such examinations shall be paid by the pool.

The Commissioner may annually develop an assessment rate based on costs incurred, and use this assessment in billing pools. This rate is included within and as stated in section XIII.B.

XII. RECORDS

To facilitate examination of each pool as required by the law the pool shall maintain the following records:

A. A complete set of accounting records shall be maintained by each pool, which shall accurately disclose the nature and detail of all accounting transactions. Such records shall at a minimum include a general ledger, a cash receipts journal and a cash disbursements journal.

B. A detailed written record of advance approval of investment transactions shall be maintained. The Board of Directors may delegate the general investment duties to a committee, an individual or investment management service, however, the board must review and, at least quarterly, ratify such investment transactions.

C. Each pool shall maintain a complaint register in the format and with the content described in Regulation 6-2-1, 3 CCR 702-6, pg 6 (5/92).

D. Each pool shall maintain minutes of meetings of the members, the board of directors and committees.

E. Each pool shall maintain a separate claim file for each claim. Information on claims shall be maintained to include medical and indemnity payments, claim number, claimant's name, date incurred, date reported, date paid, and the amount of each payment (including allocated loss adjustment expenses), and shall at the Commissioner's direction be summarized and filed in a form prescribed by the Commissioner. In addition, the pool must maintain and prepare summary loss reports and payroll reports on each member.

F. Claim files must be maintained for at least seven years. The original file or a micro film form is acceptable. A historical summary of reserve transactions and payments must be incorporated into each claim file unless this information is maintained electronically in a form which is readily accessible.

G. All board members, officers, service providers and responsible employees shall annually execute a conflict of interest affidavit disclosing any potential conflicts of interest.

XIII. ANNUAL FILING REQUIREMENTS

The pool is required to file certain reports with the Commissioner as follows:

A. The fiscal year for annual reporting purposes for a pool shall be the calendar year.

B. Each pool shall prepare and file with the Commissioner an annual report (Appendix A) prepared on a statutory basis by March 30, of each year, accompanied by a fee of one thousand dollars ($1,000 annual fee) which shall represent the cost of conducting the division examination. The report need only be signed by the chief administrative officer of the pool as designated by the

board of directors.

C. The Commissioner may if he determines it to be in the public interest require that a pool report more frequently than annually is such form as determined by the Commissioner.

D. Each pool shall annually cause to be made an audit of its statutory financial statement as of each fiscal year end and shall file the results of this audit with the Commissioner on or before August 1, of each year. Such audit shall be performed by an independent certified public accountant.

E. Annually each pool shall cause to be made an actuarial study prepared by a qualified actuary of the rates, funding and loss reserves of the pool. Such reports shall certify that the pool provide funding levels sufficient to pay obligations and maintain statutory surplus. Such report shall meet the following requirements:

1. The actuarial report shall be made by a qualified actuary.

2. The contents of the report shall set forth the underlying methods and assumptions.

3. The report shall be prepared to coincide with fiscal year end reporting requirements set forth in this regulation.

4. The Commissioner may require a special actuarial study if he deems it necessary.

5. A copy of each report (preliminary or final) shall be filed with the Commissioner upon completion.

6. The actuarial recommendations for funding shall take into account all retained risks of the pool including deductibles and risks up to statutorily required levels in excess of any reinsurance in effect.

XIV INVESTMENT OF POOL FUNDS

The board of directors is authorized to invest pool funds in the following manner:

A. Securities issued by the United States government or U.S. government agencies and which are general or full faith and credit obligations of the U. S. government.

B. Securities issued by the State of Colorado, or any agency or political subdivision which are backed by the full faith and credit of the State of Colorado.

C. Certificates of deposit and money market accounts in federally insured banks and savings and loan associations located in the State of Colorado to the extent that such investments are insured.

XV. REINSURANCE AND CREDIT FOR RESERVES ON CEDED RISKS

A. Reinsurance and excess of loss contracts which indemnify the pool must meet the requirements as set forth in § 10-3-118, C.R.S., and Regulation 3-3-2, 3 CCR 702-3, pg 83 (5/92).

B. Credit for reserves on ceded risks may only be taken if the conditions set forth in § 10-3-118, C.R.S., are satisfied.

XVI. EVIDENCE OF COVERAGE

Each member of a pool shall be issued a document specifically identifying the pool's workers' compensation coverage which must meet the minimum statutory requirements and the pool's limits for

employers liability coverage as determined by board of directors.

XVII. DISSOLUTION

A. The pool agreement shall contain procedures for the dissolution of the pool, including a requirement that the pool provide the Commissioner at least ninety (90) days advance notice of the intent to dissolve. No dissolution shall take effect until the Commissioner approves the plan of dissolution, and all debts and obligations have been paid or reinsured.

B. The plan of dissolution must require that each member remain liable for all outstanding claims liabilities and remain subject to periodic assessment until all claims are fully settled.

XVIII. FIDELITY COVERAGE

Each pool shall maintain fidelity coverage in accordance with Regulation 3-1-1, 3 CCR 702-3, pg 1 (5/92).

XIX. CONTRACT SERVICE PROVIDERS

A. Pools shall provide at least thirty (30) days advance written notice to the Commissioner of the cancellation of pool management, claims management, or investment, custodial and safekeeping contracts, except that the notice need not be given in advance for material breach of contract.

B. Unless waived by the Commissioner, self-insurance pools shall require that contract service providers which handle or have access to pool funds obtain fidelity coverage.

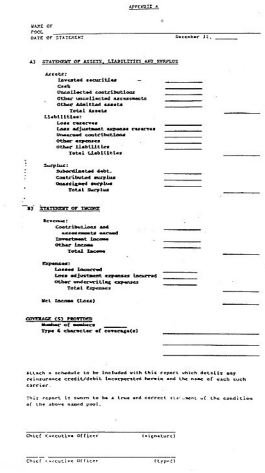
XX. SEVERABILITY

A. If any provision of this regulation is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or unenforceability shall not affect the other provisions, as this regulation is expressly declared to be severable.

XXI. EFFECTIVE DATE

This regulation is hereby amended and restated and shall be effective December 31, 1992.

APPENDIX A



APPENDIX A

NAME OF
POOL
DATE OF STATEMENT December 31, _____

A) STATEMENT OF ASSETS, LIABILITIES AND SURPLUS

Assets:
Invested securities
Cash
Uncollected contributions
Other uncollected assessments
Other Admitted assets
Total Assets
Liabilities:
Loss reserves
Unearned contributions
Unearned contributions
Other expenses
Other liabilities
Total Liabilities
Surplus:
Capitalized debt
Contributed surplus
Unassigned surplus
Total Surplus

B) STATEMENT OF INCOME

Revenue:
Contributions and assessments earned
Investment income
Other income
Total Income
Expenses:
Losses incurred
Loss adjustment expenses incurred
Other underwriting expenses
Total Expenses
Net Income (Loss)

COVERAGE (IES) RECEIVED
Number of members
Type & character of coverage(s)

Attach a schedule to be included with this report which details any reinsurance credit/debit incorporated herein and the name of each such carrier.

This report is sworn to be a true and correct statement of the condition of the above named pool.

Chief Executive Officer (signature)

Chief Executive Officer (type)

REGULATION 2-3-1 CONCERNING THE FORMATION AND OPERATIONS OF CAPTIVE INSURANCE COMPANIES IN COLORADO

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, and 10-6-129, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to set forth the formation, operation and reporting requirements for captive insurance companies formed pursuant to the Colorado Captive Insurance Company Act, Article 6 of Title 10, C.R.S., and to ensure that licensed captive insurance companies are financially sound.

Section 3 Applicability

This regulation shall apply to any person that currently has, or is seeking to obtain, a certificate of authority to transact the business of insurance as a captive insurance company.

Section 4 Filing Requirements

A. Initial Application

1. All initial applications shall include the following documents in addition to the documents required in § § 10-6-107(1) and 10-6-107(3), C.R.S.:

    a. A complete UCAA primary application;

    b. A copy of the proposed bylaws or other internal operating instructions;

    c. Three (3) years of audited financial reports on any party owning or controlling ten percent (10%) or more of the voting stock, or other controlling interest, of the captive insurance company; and

    d. The identification of the certified public accountant pursuant to Colorado Insurance Regulation 3-1-4(3 CCR 702-3), the qualified actuary as defined in Colorado Insurance Regulation 1-1-1 (3 CCR 702-1) and any managing general agent or reinsurance intermediary to be used.

2. All applicants intending to operate as a risk retention group shall also include information sufficient to demonstrate compliance with Colorado Insurance Regulation 2-1-8 (3 CCR 702-2)

B. Annual Reports

1. All group captives shall file the following documents in addition to filing the information required by § § 10-3-208(3) to 10-3-208(7), C.R.S. Unless otherwise indicated, the filings are due on the dates set by the Commissioner in the published annual filing instructions:

    a. A certification by an officer of the captive insurance company that it maintains its principal and home office in the State of Colorado, and that such office performs a significant portion of the insurance services necessary to manage and administer the captive insurance company operations, including maintaining the original books and records in the State of Colorado. This certification is due March 1st;

    b. An actuarial opinion in accordance with Colorado Insurance Regulation 3-1-3 (3

CCR 702-3);

c. An actuarial report supporting the actuarial opinion. The actuarial report is due April 1st;

d. Management Discussion and Analysis ;

e. An audited CPA financial statement prepared in accordance with Colorado Insurance Regulation 3-1-4 (3 CCR 702-3);

f. Financial Statement Supplements; and

g. Quarterly Financial Statements.

2. All pure captives shall file the flowing documents:

a. Annual financial information which includes a jurat page, balance sheet, and an income statement in the NAIC blank format. This requirement may be met by filing the audited CPA financial statement prepared in accordance with Colorado Insurance Regulation 3-1-4(3 CCR 702-3) with an affidavit by the pure captive's president, treasurer, and secretary affirming that the information in the financial statement is true and correct to the best of their knowledge. This report is due within sixty (60) days of the captive's fiscal year end;

b. A certification by an officer of the captive insurance company that it maintains its principal and home office in the State of Colorado, and that such office performs the insurance services necessary to manage and administer the captive insurance company's operations, including maintaining the original books and records in the State of Colorado. This certificate is due within sixty (60) days of the captive's fiscal year end;

c. An actuarial opinion prepared in accordance with Colorado Insurance Regulation 3-1-3 (3 CCR 702-3). The actuarial opinion is due within sixty (60) days of the captive's fiscal year end;

d. An actuarial report supporting the actuarial opinion. The actuarial report is due within ninety (90) days of the captive's fiscal year end; and

e. An audited CPA financial statement prepared in accordance with Colorado Insurance Regulation 3-1-4 (3 CCR 702-3). The audited financial statement is due within one hundred fifty (150) days of the captive's fiscal year end.

3. A pure captive that issues surety coverage, or a pure captive whose financial statement reflects a loan to or receivables from the parent company that exceeds fifty percent of the captive's statutory capital and surplus, shall file a copy of the parent company's audited financial statement. This audited financial statement is due within one hundred fifty (150) days of the captive's fiscal year end.

Section 5 Plan of Operation

A. The plan of operation filed with the Commissioner for review and approval shall provide the basis and limitations for the captive insurance company's operations. Any licensed captive insurance company shall operate within its approved plan of operation. Each plan of operation shall contain the details of the captive insurance company's proposed operations, including but not limited to the following:

1. An organizational chart which includes the proposed captive insurance company and affiliated companies or group members as defined in § 10-6-103, C.R.S.;

2. The identity of all officers and directors and owners of ten percent (10%) or more of the outstanding voting securities, or other means of direct or indirect control, of the captive insurance company, accompanied by biographical affidavits on the form prescribed by the Commissioner. The Commissioner may require a fingerprint set from any officer, director or owner;

3. Proposed contractual agreements with, and identification of, managers, administrators, claims service providers, investment advisors, custodian, or others who will furnish services or insurance expertise to the captive. Any agreement concerning essential insurance services to the captive insurance company must provide for ninety (90) days advance notice to the Commissioner prior to termination and that the captive insurance company retains full ownership of all original records. Where services are routinely provided by a parent, affiliated company, or group member, a service agreement must be executed;

4. The location(s) of all books, records and offices, including description of the functions to be performed at each office and how compliance with § 10-6-107(5), C.R.S. is achieved;

5. For pure captives, the identification of the fiscal year of the parent company and the captive (this may be the calendar year or the same fiscal year as the parent);

6. The method, plan, timing, source and amount of the proposed initial capitalization. All risk retention group captives shall maintain capital levels in compliance with Colorado Insurance Regulation 3-1-11 (3 CCR 702-3). Group captives shall maintain capital levels at such amounts as the Commissioner deems appropriate considering the risks to be insured, the amount of risk retained and other relevant factors;

7. For a pure captive, whether or not loans to the parent are anticipated. Any loan shall conform to Section 7 of this regulation;

8. Information on how the captive funds are protected;

9. A description of the type and form of risks to be written;

10. Copies of all insurance contract forms;

11. Copies of any advertising or marketing material intended for use;

12. A description of pricing or funding methods to be employed if not provided elsewhere;

13. For group captives, a description of the proposed underwriting standards and claims handling procedures;

14. Disclosure of the maximum limits proposed to be written on any one risk, including any other solvency safeguards provided, in the event of adverse experience; and

15. The identification of proposed reinsurers and a summary of the reinsurance program structure and arrangements. Draft copies of all reinsurance agreements anticipated to be used, including facultative contracts, shall be filed. Captive insurance companies, including risk retention groups, may take credit for reinsurance without prior written approval of the Commissioner if the reinsurer is authorized to transact reinsurance business in Colorado and the reinsurance agreement complies with § 10-3-118, C.R.S. and Insurance Regulation 3-3-3 (3 CCR 702-3). Captive insurance companies, with the

exception of risk retention groups, may take credit for non-complying reinsurance with approval by the Commissioner.

B. A captive insurance company may modify the approved plan of operation with prior written approval of the Commissioner. A new feasibility study may be required. If the change results in an amendment to the certificate of authority, the previously issued certificate must be returned with a completed UCAA corporate amendments application for an amended certificate of authority.

Section 6 Feasibility Study

As used in this regulation, a feasibility study is an analysis of the anticipated operations of the captive insurance company, accompanied by a report and opinion of a qualified actuary, stating that the proposed operations are anticipated to be financially sound under expected and adverse experience. The actuary shall also issue an opinion on the adequacy of the proposed capitalization and funding levels or pricing structures for the anticipated risks to be written. The actuarial report must incorporate at a minimum the applicable information contained in the submitted plan of operation and the historical and expected loss experience of the initial insureds, the credibility of such data in determining reserves, and the disclosure of any other experience of similar exposures used to provide credible loss projections. The methods and assumptions used in the feasibility study and pro forma projections are for illustrative purposes only and are not to be considered as approved methods or assumptions unless specifically requested in the plan of operation and approved by the Commissioner.

Section 7 Admitted Assets

A. A letter of credit may be reported as an admitted asset only if it is held by, or under joint control with, the Commissioner; names the Commissioner as beneficiary; has been filed and approved in the plan of operation; is used to fund capital or surplus required or permitted by the Commissioner; and meets the three following provisions. The captive, or other person responsible for reimbursing the issuer of the letter of credit, shall disclose any collateral supporting the reimbursement obligation under the letter of credit in the event of a draw, which must not include assets of the captive, or submit an affidavit that reimbursement is not supported by assets of the captive insurance company.

1. The letter of credit must be clean, irrevocable, and unconditional. Such letter of credit shall be issued by, or confirmed by, and drawn upon a Qualified United States financial institution as defined by §10-1-102(17), C.R.S. The letter of credit shall contain an issue date and date of expiration; shall stipulate that the Commissioner or representative need only draw a sight draft under the letter of credit and present it to obtain funds; and that no other document need be presented, other than the letter of credit, if required;

2. The letter of credit must not contain a statement that the obligation of the issuer under the letter of credit is contingent upon reimbursement; and

3 The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" which automatically renews it unless at least ninety (90) days notice has been given to the Commissioner that the letter of credit will not be renewed at its expiration date.

B. Pure captive insurance companies may report loans to their parent as admitted assets on their financial statements subject to the following:

1. The reported asset value for such loan must be within the maximum aggregate limit filed and approved in the plan of operation; and

a. the recipient of the loan has current assets exceeding its current liabilities, with the loan being reflected as a current liability on a non-consolidated basis with the captive; and

b. the audit opinion on the financial statement of the recipient of the loan is unqualified; and

c. the recipient of the loan does not report intangible assets, on a non-consolidated basis with the captive, in excess of one hundred percent (100%) of its net worth.

2. For situations not meeting the above conditions, prior written approval of the Commissioner must be obtained, which may include a requirement that the loan agreement provide for an automatic repayment schedule tied to some mutually agreeable index, such as the rating agency rating of the parent company.

3. Any authorized loan must be in a formal agreement containing a provision that the loan is due and payable within ninety (90) days of a written request by the Commissioner, and must contain specific interest and maturity provisions. The loan agreement must be filed with the Commissioner annually in conjunction with the filing of the annual financial information.

4. Consolidated financial information for the recipient of the loan shall be acceptable only if the report also contains consolidating worksheets.

C. A pure captive insurance company's non-admitted assets defined under § 10-1-102(16), C.R.S. or the NAIC Accounting Practices and Procedures Manual shall not be admitted assets for statutory reporting purposes.

Section 8 Reinsurance

A. Risk Retention Groups may not take credit for reinsurance agreements with unauthorized reinsurers, or which do not comply with § 10-3-118, C.R.S. and Colorado Insurance Regulation 3-3-3 (3 CCR 702-3).

B. Risk Retention Groups may not assume the liability of any other risk retention group (or any members of such other group) unless the ceding risk retention group (or member) meets the requirements for membership in the assuming risk retention group.

Section 9 Discounting of Loss Reserves

A. A captive insurance company may request written authorization to discount loss reserves for financial statements in its plan of operation. Such request shall be submitted at least sixty (60) days prior to the requested date of implementation. Discounting shall not occur until the captive insurance company receives prior written authorization from the Commissioner. This approval will not be available on a retroactive basis. Approval may be subsequently withdrawn, in whole or in part, in the event there is any material change in the acceptability of the assumptions, or the experience shows that continued loss reserve discounting fails to satisfy the standards of this section or may create a hazardous financial condition.

B. Loss reserve discounting will be permitted only for the specific types of claims authorized in the Statement of Statutory Accounting Principles.

C. The Applicant Requesting Authorization Shall:

1. Define and justify the interest rate assumptions used for discounting;

2. Provide an explanation for the basis and methodology upon which reserves are calculated;

3. Provide a summary of all available historical loss data, historical development factors, loss payout factors, and a history of the frequency and severity of past experience;

4. Provide a statement of opinion by an actuary that the funds available in the captive insurance company for payment of losses and loss expenses are adequate, at a ninety five percent (95%) confidence level, to pay all losses and loss expense obligations incurred and unpaid as of the statement date. The actuary's statement shall include the basis of accepting the captive insurance company's available loss data as being credible in order to give the required confidence level representation. Where credible loss data is not available, the actuary must disclose the data used in order to make the required confidence level representation;

5. An actuarial opinion and the supporting report evidencing compliance with the above standards must be submitted at time of application and with each annual financial report filed thereafter. The opinion must include a statement that the assets supporting the discounted reserves are sufficient to support the anticipated cash flows associated with the reserve development. Approval for discounting reserves may be withdrawn if the submitted opinion is other than unqualified.

Section 10 Examinations

The Commissioner or any person authorized will conduct a formal financial examination of every risk retention group not less frequently than once every five years.

Section 11 Severability

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

Section 12 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in § 10-3-1108, C.R.S. may be applied.

Section 13 Effective Date

This regulation is effective February 1, 2012

Section 14 History

Originally issued as Regulation 89-1, effective October 1, 1989

Amended Regulation 89-3, effective December 1, 1990

Amended Regulation 89-3, effective December 31, 1991

Recodified as Regulation 2-3-1, effective June 1, 1992

Amended Regulation 2-3-1, effective November 30, 1994

Amended Regulation 2-3-1, effective December 1, 1998

Amended Regulation 2-3-1, effective September 30, 2004

Repealed and Repromulgated Regulation 2-3-1, effective February 1, 2012.

Regulation 2-4-1 CONCERNING SURPLUS LINES INSURANCE ISSUED BY NONADMITTED INSURERS

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109, and 10-5-117, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish standards regarding the placement of insurance by producers and the qualification of insurers pursuant to the Colorado Nonadmitted Insurance Act, § 10-5-101, et seq., C.R.S. and the "Nonadmitted and Reinsurance Reform Act of 2010",Title V, Section B of the Dodd-Frank Wall Street Reform Protection Act, Public Law 111-203. This regulation also serves to further protect Colorado insurance consumers by setting forth necessary disclosure requirements for surplus lines insurance contracts.

Section 3 Applicability

This regulation shall apply to any company eligible, or seeking to become eligible, to effect a contract of insurance pursuant to Colorado's Nonadmitted Insurance Act and to any producer or Colorado surplus lines broker, as defined by § 10-5-101.2(1), C.R.S., procuring or assisting in the procurement of surplus lines insurance.

Section 4 Disclosure

A. All surplus lines insurance contracts procured or delivered in Colorado must include the following:

> **"This contract is delivered as surplus line insurance under the 'Nonadmitted Insurance Act'. The insurer issuing this contract is not admitted in Colorado but is an approved nonadmitted insurer. There is no protection under the provisions of the 'Colorado Insurance Guaranty Association Act'."**

B. In accordance with Section 10-5-119, C.R.S., if the policy is written on a claims-made basis, the following shall also appear on the policy:

> **"This policy is a claims-made policy which provides liability coverage only if a claim is made during the policy period or any applicable extended reporting period."**

C. If an automobile policy does not provide the basic complying policy coverages in § 10-4-620, C.R.S. the following must appear on the policy:

> **"This policy does not meet the statutory requirements of this State's financial responsibility laws. It does not provide liability coverage for bodily injury and property damage."**

D. The provisions of § 10-5-101.5 (1)(b), C.R.S. shall apply to policies of property and casualty insurance issued or delivered in this state by an unauthorized insurer affording coverage only on property located temporarily or permanently, or operations conducted temporarily or permanently outside the boundaries of the United States of America, its territories or possessions when the policy is placed by licensed property and casualty producers or brokers of this state, who shall remain responsible for verifying that the insuring company is licensed or authorized by the appropriate regulatory bodies to transact the business of insurance in that jurisdiction, and contains the following disclaimer:

> "This policy is issued by an insurance company that is not regulated by the Colorado Division of Insurance. The insurance company may not provide claims service and may not be subject to service of process in Colorado. If the insurance company becomes insolvent, insureds or claimants will not be eligible for protection under Colorado insurance law."

E. These required disclosures shall be affixed to the declaration page of the contract given to the insured. A copy, bearing the disclosures, shall also be maintained by the broker, in the case of the issuance of a binder prior to the formal policy, such disclosure shall also appear on the binder.

Section 5 Premium Rates

The provisions of § 10-5-103, C.R.S. allow for the use of an approved nonadmitted insurer if coverage is not available or affordable. In determining affordability, the rate quoted by each admitted insurer must exceed the rate quoted by the approved nonadmitted insurer by 10% for comparable benefits and provisions.

Section 6 Procurement

Section 10-5-103, C.R.S. requires that a diligent effort be made to procure coverage with an admitted insurer before placing coverage with an approved nonadmitted insurer.

A. Due diligence shall be satisfied by documentation prepared by the producer, office of the producer or broker. The documentation must demonstrate that the coverage required was not procurable after a comprehensive search was made from a minimum of three admitted insurers authorized to and

currently transacting that line of business in this state. If there are fewer than three admitted insurers in this state which are authorized and currently transacting the line of business needed, such diligent effort shall be met by searching this lesser market.

B. A written record documenting diligent search efforts shall be maintained by the broker or producer for a period of not less than three years from the effective date of the coverage. The broker may rely upon representations made by a producer with regard to search efforts made by the producer.

C. Given that availability and affordability of coverages is continually changing, the determination of placement and evidence of diligent search efforts must be made each policy period prior to placement of coverage with an approved nonadmitted insurer.

D. If the insurance transaction is primarily for automobile liability to meet the financial responsibility requirements in Colorado any approved surplus lines carrier must comply with the provisions of § 10-4-601 et. seq, C.R.S., including § 10-4-633 C.R.S., and with the reporting requirements contained in §10-4-615, C.R.S.

Section 7 Taxes on Premium

A. Each broker shall treat all premium tax revenues received for surplus lines insurance written in Colorado in a fiduciary capacity.

B. Each broker shall, no later than the 15th of each month for the prior month, submit a report to the Division of Insurance showing each policy written including those accepted from licensed producers. The report shall include the name of the insured, line of business, name of non admitted insurer, surplus lines premium, policy fees charged and surplus lines taxes due. Such report shall be on a form prescribed by the Commissioner.

C. In accordance with §10-5-109, C.R.S., a broker reporting a policy written with a nonadmitted insurer that is not listed on the Division of insurance's approved list is required to retain documentation verifying that the non admitted insurer meets the requirements of Sec,. 524 of the Nonadmitted and Reinsurance Reform Act of 2010, or the type of insurance is listed in § 10-5-101.5, C.R.S.

Section 8 Approved List

A. The Commissioner will prepare, at least annually, a listing of those nonadmitted insurers whose filings have been reviewed by the Division of Insurance and found to meet the qualification requirements of Sec. 524 of the Nonadmitted and Reinsurance Reform Act of 2010. Such list will be effective from July 1 of each year through June 30 of the following year unless otherwise amended.

B. The Commissioner, within his/her discretion, may consider a filing received during the current approval period. If such filing is approved, such approval will expire on June 30 following acceptance.

Section 9 Filings

A. A foreign or alien nonadmitted insurer that wants to be included on the Division of Insurance's approved list shall, on or before March 1st of every year, submit to the Division a completed form approved by the Commissioner and the fees as prescribed by Sections 10-3-207 and 10-3-207.5, C.R.S.

B. An Insurance Exchange; a Lloyds plan, or other similar unincorporated group of individual insurers or a combination of both unincorporated and incorporated insurers; or a group of incorporated insurers under common administration, shall annually file such other information necessary to determine compliance with the conditions contained in § 10-5-108, C.R.S.

Section 10 Standards for Approval

A. A foreign company seeking inclusion on the approved list of nonadmitted insurers must meet the qualification requirements and criteria contained in section 5A(2) and 5C(2)(a)(i) of the National Association of Insurance Commissioners' Non-Admitted Insurance Model Act unless Colorado has adopted nationwide uniform requirements, forms and procedures in accordance with section 521(b) of the Nonadmitted and Reinsurance Reform Act of 2010.

B. An alien company seeking inclusion on the approved list of nonadmitted insurers must be listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC.

C. A foreign insurer with less than the $15,000,000 minimum required capital and surplus may make formal request of the Commissioner that they be given consideration for approval as an Approved Nonadmitted insurer. Companies applying for special consideration must demonstrate at a minimum: 1) that they primarily write risks for which they maintain a specialty; 2) exceptional expertise in these specialty risks; and 3) sufficient surplus for the potential volatility of the risks written. Applications should be accompanied by an actuarial opinion and a supporting report specifically addressing the sufficiency of reserves and surplus for the risks written and anticipated to be written. Additionally, the applicant shall provide a copy of the audited financial report of the parent and the ultimate controlling company (person), if any, and any other additional information requested by the Commissioner.

Section 11 Severability

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

Section 12 Enforcement

Noncompliance with the Regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in § 10-3-1108, C.R.S. may be applied.

Section 13 Effective Date

This amended regulation shall be effective March 1, 2012.

Section 14 History

New Regulation 90-14, effective January 1, 1991.

Amended Regulation effective February 1, 1996.

Executive Order D0004-97 reviewed December 1998.

Amended Regulation effective April 1, 2000.

Amended Regulation effective March 2, 2002.

Sections 4.C. and 6.D. amended effective February 1, 2004.

Amended Regulation effective January 1, 2007.

Amended Regulation effective January 1, 2009.

Amended Regulation effective March 1, 2012.

REGULATION 2-6-1 CONCERNING ATTORNEYS IN FACT FOR RECIPROCAL OR INTERINSURANCE EXCHANGES

I. AUTHORITY

This regulation is promulgated under the authority of § § 10-1-108(8), 10-1-109 and 10-13-106, Colorado Revised Statutes (C.R.S.).

II. PURPOSE

Pursuant to § 10-13-103(1), C.R.S., persons who wish to form and license a reciprocal or interinsurance exchange must furnish to the Division of Insurance, among other things, a copy of the form of policy contract or agreement under or by which such insurance is to be effected or exchanged and a copy of the form of power-of-attorney or other authority under which the insurance is to be effected or exchanged. Pursuant to § 10-13-106(1), C.R.S., it is the duty of the Commissioner of Insurance (Commissioner) to "examine and pass upon" this information, along with the other information furnished with the application for licensure. The purpose of this regulation is to describe what the Commissioner requires in such documents. This regulation sets forth, among other things, certain criteria and requirements which must be met before the Division of Insurance will issue a license for the operation of an interinsurance or reciprocal exchange, pursuant to § 10-13-111, C.R.S.

III. DEFINITIONS

A. "Affiliate" means a person who directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with another person.

B. "Attorney-in-fact" means a person designated and appointed by subscribers to a reciprocal insurer to act for and bind the subscribers in all transactions relating to or arising out of the operations of a reciprocal insurer, subject to limitations as may be lawfully provided.

C. "Books, accounts and records" means all working papers, ledgers, and other relevant documents which demonstrate, disclose and support transactions of the reciprocal and each individual subscriber distinguished from the attorney-in-fact and which relate to the operations and activities of the reciprocal. The phrase "books, accounts and records" shall not mean or include working papers, ledgers, or other relevant documents which relate exclusively to the operation and activities of the attorney-in-fact as a separate entity.

D. "Material transactions" means transactions, other than claim payments, involving more than one-half of one percent (.5%) of the reciprocal's admitted assets as of the 31st day of December of the prior year.

E. "Person" means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert.

F. "Reciprocal" or "interinsurance exchange" means any aggregation of persons, known as subscribers, who, under a common name, engage in the business of interinsurance or exchanging contracts of insurance on the reciprocal plan through an attorney-in-fact having authority to obligate the subscribers severally, within such limits as may lawfully be specified in the subscriber's agreement, on contracts of insurance made with other subscribers.

G. "Subscriber" means a person who has become a member of a reciprocal through the execution of

a subscriber's agreement.

H. “Subscriber's agreement” means a document executed by the subscriber which designates and appoints, through a power of attorney, the attorney-in-fact and, either within the agreement or via an appended set of bylaws, spells out the duties of the attorney-in-fact.

I. “Subscribers' advisory committee” or “committee” means a board, committee, council or any equivalent body made up of subscribers or other governing body acceptable to the Commissioner which oversees the operations of the attorney-in-fact to such extent as may be necessary to protect the public and to assure conformity with the subscriber's agreement and power of attorney for the benefit of all subscribers.

IV. SCOPE

A. This Regulation shall apply to all reciprocals domiciled in this state.

B. A subscribers' agreement containing the duties of the attorney-in-fact, as specified herein, shall be provided to all subscribers.

V. DERIVATION OF AUTHORITY OF ATTORNEY-IN-FACT TO MANAGE THE AFFAIRS OF A RECIPROCAL

A. The authority of the attorney-in-fact to manage the affairs of the reciprocal shall be derived from the subscriber's agreement executed by each subscriber, which agreement shall provide for a subscribers' advisory committee.

B.(1) The subscribers' advisory committee shall meet at least annually and shall consist of not less than nine (9) individuals elected by the subscribers, at least two-thirds of whom are subscribers or officers or directors of subscriber corporations and, except for a reciprocal which wholly owns its attorney-in-fact, not more than one-third of whom may be:

(a) The attorney-in-fact or an employee, officer, director, affiliate or any person having a financial interest in the attorney-in-fact; or

(b) Any person representing the attorney-in-fact or an employee, officer, director, affiliate or any other person having a financial interest in the attorney-in-fact.

(c) A person shall be treated as having a “financial interest” in the attorney-in-fact if such person:

(i) owns, directly or indirectly, more than one percent of the outstanding stock in the attorney-in-fact;

(ii) Has any outstanding loans from the attorney-in-fact; or

(iii) Earns a commission or other compensation as a producer for the reciprocal.

(2) Members of the subscribers' advisory committee may be elected and re-elected to a term of office of not less than one year nor more than four (4) years and may be staggered to provide for continuity.

(3) The chairman of the committee shall be elected by the other members of the committee and the committee shall adopt rules consistent with its purposes as stated in Item I of section III of this regulation.

(4) The attorney-in-fact shall designate a person other than the attorney-in-fact to act as secretary, without a vote.

(5) Special meetings of the committee may be called by the attorney-in-fact, the chairman of the committee, any three (3) members of the committee, or a signed petition of at least one percent of the subscribers as of the most recent annual report of the reciprocal.

C. The duties of the attorney-in-fact shall be specified in the subscriber's agreement. Such agreement, and any amendments thereto, shall be approved by the Commissioner and the subscribers' advisory committee; and shall, at a minimum, contain provisions that:

(1) The attorney-in-fact shall provide written notification of and make all necessary arrangements as provided in the subscriber's agreement, for the election, in person or by proxy, of the members of the subscribers' advisory committee. The cost of notification, ballot, proxy for any meeting and the cost of any meeting which may be called for the election shall be incurred by the reciprocal.

(2) The attorney-in-fact shall provide written notification to the members of the subscribers' advisory committee of not less than ten (10) business days for any regular meeting or for any special meeting called pursuant to subsection B(5) of this section. The cost of such notification shall be incurred by the reciprocal.

(3) The subscribers' advisory committee may, upon a vote of a majority of its members at any regular or special meeting thereof and upon written notice to the Commissioner, and the attorney-in-fact, recommend termination of the attorney-in-fact for a stated cause and appointment of a new attorney-in-fact. Termination of the attorney-in-fact shall require the approval of at least two-thirds majority of the subscribers present in person or by proxy at a special meeting called for that purpose. The attorney-in-fact shall provide by mail not less than thirty (30) days prior written notification of the meeting to all subscribers.

The mailing of notification shall include the recommendation of termination and replacement as drafted by the committee and any other appropriate documents drafted by the attorney-in-fact. A copy of all documents mailed and certification of their mailing to all subscribers shall be provided to all members of the committee. The cost of notification and proxy for any meeting shall be incurred by the reciprocal. For reciprocals with less than 10,000 subscribers, at least twenty-five percent (25%) of all subscribers shall be required to constitute a quorum. For all other reciprocals, the greater of 2,500 subscribers or five percent (5%) of all subscribers shall constitute a quorum.

(4) All assets of the reciprocal and its subscribers shall be invested in accordance with investment guidelines approved by the committee and shall be properly accounted for on the financial records of the reciprocal as being held for or on behalf of the subscribers. All cash assets of the reciprocal and its subscribers, not otherwise invested in short term securities such as money market funds, covering policy obligations arising out of policies issued or issued for delivery in the United States shall be held in one or more appropriately identified accounts in banks that are members of the Federal Reserve System. These accounts shall be drawn on by the attorney-in-fact, or by employees or representatives of the reciprocal authorized by the attorney-in-fact for all payments on behalf of the reciprocal.

(5) If the attorney-in-fact is acting for more than one reciprocal, separate records and accounts shall be maintained for each reciprocal.

(6) The attorney-in-fact may not assign his/her responsibilities as detailed in the subscriber's agreement in whole or in part without the prior approval of the subscribers' advisory

committee and the Commissioner.

(7) The attorney-in-fact shall establish and maintain underwriting procedures and manuals setting forth the rates and conditions for the acceptance or rejection of risks.

(8) The attorney-in-fact shall make a report to the subscribers' advisory committee at the committee's each regular meeting on the financial condition of the reciprocal and all material transactions entered into during the period since the last meeting.

(9) The attorney-in-fact shall annually provide to each member of the committee:

(a) On or before March 1, a copy of the reciprocal's annual statement and the accompanying statement of actuarial opinion filed with the Commissioner pursuant to § 10-13-108, C.R.S. and regulation 3-1-3; and

(b) On or before June 1st, a copy of:

(i) A statement prepared by an independent certified public accountant addressing the financial condition and solvency of the attorney-in-fact. The statement shall confirm that the attorney-in-fact is an ongoing concern and is financially solvent under generally accepted accounting principles; and

(ii) The audited financial report of the reciprocal filed with the Commissioner pursuant to regulation 3-1-4.

(10) Specify all forms and amounts (or formulas to determine the amounts) of compensation the attorney-in-fact will receive for services rendered.

(11) The books, accounts and records of the reciprocal, its subscribers and the attorney-in-fact shall be so maintained as to clearly and accurately disclose the nature and details of all transactions including all information as is necessary to determine that the compensation received by, or owing to, the attorney-in-fact is as provided in the subscriber's agreement. The books, accounts and records of the reciprocal shall be the sole property of the reciprocal.

(12) If the subscribers' agreement provides that some or all of the attorney-in-fact's compensation is contingent upon the reciprocal's profits, then such compensation shall not be determined and paid until at least five (5) years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other kind of insurance and, in no event, until the adequacy of reserves on the remaining claims has been verified pursuant to Paragraph (9) of this subsection.

(13) The independent certified public accountant who will prepare the annual report required by Regulation 3-1-4 shall be selected by the attorney-in-fact, subject to the approval of the subscribers' advisory committee.

(14) The attorney-in-fact shall conduct the affairs of the reciprocal in accordance with the Insurance Law.

D. Unless subject to § 10-3-801 et seq , C.R.S., all material transactions between the reciprocal, its subscribers, the attorney-in-fact and any affiliate of the attorney-in-fact shall not be entered into unless they have been filed with the Commissioner at least thirty (30) days prior thereto and the Commissioner has not disapproved them; provided, however that any such transaction involving five percent (5%) or more of admitted assets shall be subject to prior approval of the

Commissioner and all transactions shall meet the following standards:

(1) The terms shall be fair and equitable;

(2) Charges or fees for services performed shall be, reasonable; and

(3) Expenses incurred and payments received shall be allocated to the reciprocal on an equitable basis in conformity with statutory insurance accounting practices consistently applied.

VI. EXAMINATION OF THE ATTORNEY-IN-FACT

An attorney-in-fact of a reciprocal shall be subject to examination by order of the Commissioner for the purposes of determining compliance with this Regulation and all other relevant provisions of the Insurance Law relating to the operations of the reciprocal or its attorney-in-fact which the Commissioner determines, as specified in the order, cannot be obtained by examination of the reciprocal. The cost of the examination shall be assessed against the attorney-in-fact and no portion thereof shall be reimbursed directly or indirectly by the reciprocal or its subscribers.

VII. SEVERABILITY

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

VIII. EFFECTIVE DATE

This Regulation shall take effect on May 1, 1992.

Editor's Notes

History

Regulations 2-1-9, 2-4-1 eff. 01/01/2009.

Regulation 2-1-10 eff. 04/01/2009.

Regulation 2-3-1 eff. 02/01/2012.

Regulations 2-1-7, 2-4-1; Regulation 2-1-4 repealed; eff. 03/01/2012.