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 CONCERNING THE FINANCIAL RESPONSIBILITY REQUIREMENTS FOR HEALTH CARE INSTITUTIONS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, and 13-64-301(1)(b), C.R.S.

Section 2 Scope and Purpose

The purpose of amending this regulation is to clarify for the applicant the documents and information that 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 Applicability

This regulation applies to all health care institutions that are required to establish financial responsibility as set forth in § 13-64-301(1)(b), (c), (d) and (e), C.R.S.

Section 4 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 5 Requirements for Establishing Financial Responsibility

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: commercial professional liability insurance coverage in an amount established by statute; a surety bond in a form acceptable to the Commissioner; cash or cash equivalents on deposit with the Commissioner; or any other security, acceptable to the Commissioner, which may include a plan of self-insurance.

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 maintaining 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.

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 6 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 5 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 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 § 13-64-301 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 7 Plan 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 8 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 9 Enforcement

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

Section 10 Effective Date

This amended regulation shall be effective on November 1, 2012.

Section 11 History

Originally promulgated September 1, 1989.
Amended and effective June 1, 1990.
Amended and effective November 1, 1999.
Amended regulation effective November 1, 2012.

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

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 Scope 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 Applicability

This regulation applies to all companies seeking qualification as a regional home office in Colorado in accordance with §10-3-209(1)(b)(I)(B), C.R.S.

Section 4 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 7B. 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, and attachments specified by the application form and instructions. Due dates for the complete application must be in accordance with Section 5 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.

D. 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 in §10-3-209(1)(b)(I)(A), C.R.S.

Section 5 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 6, of the company's performance of the mandated functions.

D. Renewal Applications must be received on or before March 1 of the year for which qualification is being made. 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 6 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 7 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.

C. 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.

D. If the applicant has made an application under either standard 7A. or 7B. above, and fails to qualify, no other application shall be considered for the same year.

Section 8 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 9 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 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 may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 12 Effective Date

This regulation is effective on August 1, 2013.

Section 13 History

Amended and Restated December 31, 1996.
Amended effective January 1, 2002.
Amended regulation effective August 1, 2013.

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

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 13-64-301, and 12-40-126, C.R.S.

Section 2 Scope and Purpose

The purpose of amending this regulation is to clarify for the applicant the documents and information that are acceptable to the Commissioner to establish financial responsibility in compliance with § 13-64-301(1)(a),(a.5),(c), (d) and (e), C.R.S. and 12-40-126 (1)(b), (c) and (d), C.R.S.

Section 3 Applicability

This regulation applies to all health care professionals that are required to establish financial responsibility as set forth in § § 13-64-301(1), (c), (d), and (e), C.R.S. and 12-40-126 (1)(b), (c), and (d), C.R.S.

Section 4 Definitions

A. "Applicant" as used in this regulation means a physician licensed by the Colorado Medical Board, a dentist licensed by the Colorado State Board of Dental Examiners, an optometrist licensed by the Colorado State Board of Optometry, or a corporation or other entity which is assuming the exposure risks of the underlying licensed physicians, dentists, or optometrists.

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

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

D. "Professional" as used herein means a physician, dentist or optometrist.

Section 5 Requirements for Establishing Financial Responsibility

The financial responsibility requirements are mandated in § § 13-64-301, and 12-40-126 C.R.S. for applicants who 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: commercial professional liability insurance coverage; a surety bond; cash or cash equivalents; or any other security, acceptable to the commissioner, which may include a plan of self insurance.

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 professional license with the appropriate licensing board.

B. 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.

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. The Colorado Medical Board, the Colorado State Board of Dental Examiners or the Colorado State Board of Optometry 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.

E. Surety Bonds

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

   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 prescribed in § 13-64-301 (1), or § 12-40-126 (1) C.R.S., plus whatever remaining liability there may be for prior year’s coverage.

F. 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 prescribed in § 13-64-301 (1), or § 12-40-126 (1) C.R.S., plus whatever remaining liability there may be for prior year's coverage.

G. 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 G. 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 G., 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.

Section 6 Evidence of Compliance

A. The Commissioner shall issue a letter of approval for those applicants who meet the requirements under items E, F or G of section 5 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;

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.

Section 7 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 8 Enforcement

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

Section 9 Effective Date

This amended regulation shall be effective on November 1, 2012.

Section 10 History

Originally promulgated January 1, 1990.
Amended regulation effective November 1, 2012.

Regulation 2-1-4 [Repealed eff. 03/01/2012]

Regulation 2-1-5 [Repealed eff. 06/01/2012]

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 § 10-3-701 et. seq., 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 from the three most recent year-end financial statements, 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 or affiliate of an insurance company with common management and operations licensed or 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, or

5. Is determined by the Commissioner to:

a. Demonstrate adequate surplus strength;

b. Have made a special deposit with the Commissioner for the sole benefit of Colorado policyholders;

c. Have submitted sufficient documentation detailing such mitigating factors as the severity, cause(s), and timing of statutory losses; surplus strength of the applicant; and financial strength of the applicant's parent and/or other affiliates licensed in Colorado and under common control with the applicant; and

d. Be in the public interest to grant the waiver.

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 any 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.

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

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

I. The most recent financial examination of the applicant must be submitted to the commissioner and have an "as of" date no more than five years prior to 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 § 10-3-701 et. seq., 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 civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective Date

This regulation shall become effective January 1, 2017.

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 effective January 1, 2017.

Regulation 2-1-8 CONCERNING RISK RETENTION GROUPS AND PURCHASING GROUPS

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109 and 10-3-1403, C.R.S.

Section 2 Scope and 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 Applicability

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. "Board of directors" or "board" means, for the purposes of this regulation, the governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions.

B. “Completed operations liability” means, for the purposes of this regulation, 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.

C. “Director” means, for the purposes of this regulation, a natural person designated in the articles of the risk retention group, or designated, elected or appointed by any other manner, name or title to act as a director.

D. “Domicile”, , for the purposes of this regulation, and for the 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.

E. “Hazardous financial condition” means, for the purposes of this regulation, 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.

F. “Insurance” means, for the purposes of this regulation, 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.

G. “Liability” means, for the purposes of this regulation, 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.).

H. “Personal risk liability” means, for the purposes of this regulation, 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.G.

I. “Plan of operation or a feasibility study” means, for the purposes of this regulation, 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 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.

J. “Product liability” means, for the purposes of this regulation, 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.

K. “Purchasing group” means, for the purposes of this regulation, 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 Section 4.K.3.;

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.

L. “Risk retention group” means, for the purposes of this regulation, 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 Section 4.L.1.;

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:

(1) Its members only persons who comprise the membership of the risk retention group; and

(2) 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 4.L.6.for membership in the risk retention group which provides such reinsurance; and

8. The name of which includes the phrase “Risk Retention Group”.

M. “State” means, for the purposes of this regulation, any state of the United States or the District of Columbia.

N. “NAIC” means, for the purposes of this regulation, 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 of Insurance 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.

E. Governance Standards for Risk Retention Groups

1. The board of directors of the risk retention group shall have a majority of independent directors. If the risk retention group is a reciprocal, then the attorney-in-fact would be required to adhere to the same standards regarding independence of operation and governance as imposed on the risk retention group’s board of directors/subscribers advisory committee. Under these standards and, to the extent permissible under state law, service providers of a reciprocal risk retention group should contract with the risk retention group and not the attorney-in-fact.

2. No director qualifies as “independent” unless the board of directors affirmatively determines that the director has no “material relationship” with the risk retention group. Each risk retention group shall disclose these determinations to its domestic regulator, at least annually. For this purpose, any person that is a direct or indirect owner of or subscriber in the risk retention group (or is an officer, director and/or employee of such owner and insured, unless some other position of such officer, director and/or employee constitutes a “material relationship”), as contemplated by 15 U.S.C. § 3901(a)(4)(E)(ii) of the Liability Risk Retention Act, is considered to be “independent”.

3. “Material relationship” of a person with the risk retention group includes, but is not limited to:

   a. The receipt in any 12-month period of compensation or payment of any other item of value by such person, a member of such person’s immediate family or any business with which such person is affiliated from the risk retention group or a consultant or service provider to the risk retention group is greater than or equal to five percent (5%) of the risk retention group’s gross written premium for such 12-month period or two percent (2%) of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in the 12-month period. Such person or immediate family member of such person is not independent until one year after his/her compensation from the risk retention group falls below the threshold.

b. A relationship with an auditor as follows: a director or an immediate family member of a director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor until one year after the end of the affiliation, employment or auditing relationship.

c. A relationship with a related entity as follows: a director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on that other company's board of directors is not independent until one year after the end of such service or the employment relationship.

4. The term of any material service provider contract with the risk retention group shall not exceed five years. Any such contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's board of directors shall have the right to terminate any service provider, audit or actuarial contracts at any time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for such contract is greater than or equal to five percent (5%) of the risk retention group's annual gross premium or two percent (2%) of its surplus, whichever is greater.

a. For the purposes of this standard, "service providers" shall include captive managers, auditors, accountants, actuaries, investment advisors, lawyers, managing general underwriters or other party responsible for underwriting, determination of rates, collection of premium, adjusting and settling claims and/or the preparation of financial statements. Any reference to 'lawyers' in the prior sentences does not include defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to such lawyers are 'material' as referenced in Section 5.1.b. of this regulation.

b. No service provider contract meeting the definition of "material relationship" contained in Section 5.1.b. of this regulation shall be entered into unless the risk retention group has notified the Commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto and the Commissioner has not disapproved it within such time.

5. The risk retention group's board of directors shall adopt a written policy in the plan of operation as approved by the board that requires the board to:

a. Assure that all owners/insureds of the risk retention group receive evidence of ownership interest;

b. Develop a set of governance standards applicable to the risk retention group;

c. Oversee the evaluation of the risk retention group's management including but not limited to the performance of the captive manager, managing general underwriter or other party or parties responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims or the preparation of financial statements;

d. Review and approve the amount to be paid for all material service providers; and

e. Review and approve, at least annually:

(1) Risk retention group's goals and objectives relevant to the compensation of officers and service providers;

(2) The officers' and service providers' performance in light of these goals and objectives; and,

(3) The continued engagement of the officers and material service providers.

6. Audit Committee – The risk retention group shall have an audit committee composed of at least three independent board members. A non-independent board member may participate in the activities of the audit committee, if invited by the members, but cannot be a member of such committee.

a. The audit committee shall have a written charter that defines the committee's purpose, which at a minimum, must be to:

(1) Assist board oversight of the integrity of the financial statements, the compliance with legal and regulatory requirements, and the qualifications, independence and performance of the independent auditor and actuary;

(2) Discuss the annual audited financial statements and quarterly financial statements with management;

(3) Discuss the annual audited financial statements with its independent auditor and if advisable, discuss its quarterly financial statements with its independent auditor;

(4) Discuss policies with respect to risk assessment and risk management;

(5) Meet separately and periodically, either directly or through a designated representative of the committee, with management and independent auditors;

(6) Review with the independent auditor any audit problems or difficulties and management's response;

(7) Set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor;

(8) Require the external auditor to rotate the lead (or coordinating) audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing that audit so that neither individual performs audit services for more than five consecutive fiscal years; and

(9) Reports regularly to the board of directors.

b. If an audit committee is not designated by the risk retention group, the entire board of directors of the risk retention group shall constitute the audit committee.

7. Governance Standards – The board of directors shall adopt and disclose governance standards, where "disclose" means making such information available through electronic (e.g., posting such information on the risk retention group's website) or other means, and providing such information to members/insureds upon request, which shall include:

a. A process by which the directors are elected by the owners/insureds;

b. Director qualification standards;

c. Director responsibilities;

d. Director access to management and, as necessary and appropriate, independent advisors

e. Director compensation;

f. Director orientation and continuing education;

g. The policies and procedures that are followed for management succession; and

h. The policies and procedures that are followed for annual performance evaluation of the board.

8. Business Conduct and Ethics – The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers and employees and promptly disclose to the board of directors any waivers of the code for directors or executive officers, which should include the following topics:

a. Conflicts of interest;

b. Matters covered under the corporate opportunities doctrine under the state of domicile;

c. Confidentiality;

d. Fair dealing;

e. Protection and proper use of risk retention group assets;

f. Compliance with all applicable laws, rules and regulations; and

g. Requiring the reporting of any illegal or unethical behavior which affects the operation of the risk retention group.

9. Reporting Non-Compliance – The captive manager, president or chief executive officer of the risk retention group shall promptly notify the domestic regulator in writing if either becomes aware of any material non-compliance with any of these governance standards.

10. Compliance dates

a. Existing risk retention groups shall be in compliance with the standards of Section 5.E. of this regulation no later than October 1, 2018.

b. New risk retention groups shall be in compliance with the standards of Section 5.E. of this regulation at the time of licensure.

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 Section 4.L.;

    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:

        (1) Was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

        (2) 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 Section 6.A.1.b. 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.L.

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, specifically § 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 Section 6.E.

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 Section 8.B.;

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 Section 4.K.

B. A purchasing group shall, within ten (10) days, notify the Commissioner of any changes in any of the items set forth in Section 9.A.

C. The purchasing group shall register and designate the Commissioner as its agent solely 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 Incorporated Materials

15 U.S.C. § 3901(a)(4)(E)(ii), the Liability Risk Retention Act, published by the Government Publishing Office shall mean 15 U.S.C. § 3901(a)(4)(E)(ii) 3901(a)(4)(E)(ii), as published on the effective date of this regulation and does not include later amendments to or editions of 15 U.S.C. § 3901(a)(4)(E)(ii). A copy of 15 U.S.C. § 3901(a)(4)(E)(ii) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 15 U.S.C. § 3901(a)(4)(E)(ii) may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at www.uscode.house.gov

Section 14 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 14 Enforcement

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

Section 16 Effective Date

This amended regulation shall become effective on October 1, 2017.

Section 17 History

Regulation amended and restated effective December 1, 1992
Amended regulation effective April 1, 2004
Amended regulation effective July 1, 2012
Amended regulation effective October 1, 2017

Regulation 2-1-9 CONCERNING THE LICENSURE OF LIMITED SERVICE LICENSED PROVIDER NETWORKS

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.

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 limited health services, 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 purpose of this regulation is to establish requirements for licensure as a limited service licensed provider network, and to clarify the applicability of health benefit mandates and Title 10 requirements to limited service licensed provider network health coverage plans.

Section 3 Definitions

A. "Capitation" means, for the purpose of this regulation, 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, and does not vary on the basis of the number or type of services actually rendered.

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

C. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

D. "Employee assistance program" shall mean, for the purpose of this regulation, 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 that may affect job performance.

E. "Health care coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.

F. "Home health care services" shall mean, for the purpose of this regulation, the following services when provided to a covered person in his/her place of residence:

1. Skilled nursing services; home health aide services;

2. Provision of medical supplies, equipment, and appliances suitable for use in the home; and

3. Physical therapy, speech and hearing therapy, or occupational therapy.

G. “Incidental services” means, for the purpose of this regulation, fees only for x-rays, laboratory services, medications, and other services as approved by the commissioner.

H. “Inpatient hospital services” means, for the purpose of this regulation, 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” or “LSLPN” means, for the purpose of this regulation, 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:

1. A narrowly defined health specialty (e.g., substance abuse, radiology, mental health, pediatrics, pharmacology, etc.), or

2. Services narrowly limited to a single type of licensed health facility (e.g., inpatient hospital, birth center, long term care facility, hospice, etc.), or

3. Home health care services delivered in the covered person’s residence only.

J. “Limited service licensed provider network health coverage plan” or “LSLPN health coverage plan” means, for the purpose of this regulation, 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 found at § 10-2-103(6), C.R.S.

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

M. “Risk assumption” or “risk sharing” means, for the purpose of this regulation, 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” or “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 determinant.

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 (HMO) that contracts with provider networks for the delivery or provision of health care services; and

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

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, however.

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, 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:

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

(2) 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 (HMO) pursuant to § 10-16-102(35), C.R.S. or, in the commissioner's opinion, offers services which do not differ substantively from the basic services offered by an HMO, or that provides comprehensive or major medical services to enrollees, either directly or through contractual or other arrangements with other hospitals and/or physicians, shall not be eligible for licensure as an LSLPN.

C. 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. 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.

D. The commissioner may refuse to issue an LSLPN license to any provider or provider network, 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 (1) copy of each of the following:

1. An application to be licensed as an LSLPN. Such application shall:

a. 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.);

b. Be accompanied by a non-refundable filing fee of five hundred dollars ($500); and

c. 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:

a. 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;

b. Its capital structure;

c. A quantitative measurement of its capacity to provide contracted services;

d. 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.);

e. A description of the network's geographical service area; and

f. 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, Biographical Affidavit (available upon request), along with a complete set of fingerprints, as may be secured from local law enforcement sources, which shall be forwarded 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 when deemed appropriate.

4. A current audit report, certified by an independent certified public accountant, of the applicant's 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 statements of cash flow must be provided. The financial projections shall contain projected per member per month enrollment at its fiscal year end, and a concise summary of all assumptions used to generate the projections.

5. A copy of the LSLPN'S proposed 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 with 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 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. If any contract is found to be contrary to the best interests of the public, the LSLPN will be expected to amend or terminate the contract.

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 access to additional capital, stop-loss insurance, business interruption insurance, 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 the calculation of the rate or charge (e.g., use of usual, customary, and reasonable (UCR) rates).

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, the LSLPN must, in no less than thirty (30) days prior to the anticipated change, 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. Maintaining an unqualified annual audited financial report certified by an independent certified public accountant (CPA), performed in accordance with Generally Accepted Auditing Standards (GAAS), which is 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. Demonstrating financial stability to the commissioner and maintaining a minimum net worth. Minimum net worth, excluding any goodwill or other intangible assets, must be equal to the greatest of:

1. One hundred thousand dollars ($100,000);

2. Two (2) times the authorized control level of the most recent risk based capital calculation; or

3. Such other amount as may be determined by the commissioner and commensurate with the risks assumed by the LSLPN.

C. Demonstrating its capacity to administer the health plans being offered; its ability to achieve, monitor, and evaluate the quality and cost effectiveness of care being provided by its health care providers; and the adequacy of its provider network and third-party agreements in assuring reasonable access to care.

D. Providing 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. Providing an annual certification by an executive officer of the LSLPN attesting that LSLPN health coverage plan(s), contracts or agreements or a combination thereof are not being offered and marketed as a substitute for comprehensive or major medical insurance coverage.

F. Assuring that all administrative and management agreements include:

1. A provision that the contract may not restrict the LSLPN governing body from appointing, removing or changing officers or employees of the LSLPN;

2. A clear statement of the responsibilities and ownership of all books and records, assets, liabilities and compensation under the contract, where applicable; and

3. 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. Providing 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; and

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 subject to the joint control of the commissioner for the protection of Colorado contract holders. The securities must be in marketable securities and should, at all times, be of top quality, readily marketable, and have a fair market value 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 contract holders from misuse of contract holder 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 (3 CCR 702-3).

Section 10 Annual Reporting and Licensing Procedures

A. The license shall expire on September 1 of 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 license shall be deemed renewed if the LSLPN is in compliance with the provisions of Section 7 of this regulation, and does all of the following:

1. Remits an annual filing fee of five hundred dollars ($500) by September 1.

2. Remits annually by September 1 the greater of one hundred dollars ($100) 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:

   a. All LSLPNs 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.

   b. The annual audited financial report shall include:

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

      (2) The amount of all capitation fees/premiums collected during the fiscal year;

      (3) The amounts actually paid/allocated during such year for health care and incidental services for the covered persons;

      (4) 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;

      (5) All other liabilities and obligations required of such LSLPN;

      (6) The number of members and member months; and

      (7) Such other information relating to the performance of the LSLPN as is necessary to enable the commissioner to carry out his/her duties.

4. Files a complete Risk Based Capital report for the same period of time.

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

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.

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 benefits (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 that 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 language:

"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 contract holder/enrollee is entitled;

2. Any limitation of the service, kinds of service or benefits to be provided, and any 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 contractholder/enrollee in a separate document at least thirty (30) days prior to the effective date of the amendment.

Section 13 Complaint System

A complaint system shall be maintained by all LSLPNs and shall be in compliance with § 10-3-1104(1)(i), C.R.S.

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.

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 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 18 Enforcement

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

Section 19 Effective Date

This regulation shall become effective on February 1, 2016.

Section 20 History

Originally adopted November 1, 1996.
Amended effective November 1, 2003.
Amended effective January 1, 2009.
Regulation amended effective February 1, 2016.

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.

A. 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 (GAAP).

B. The annual audited financial report shall include the following:

i. Report of independent certified public accountant;

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

iii. Statement of operations;

iv. Statement of cash flows;

v. Statement of changes in net worth; and

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

C. 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 shall 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 American Institute of Certified Public Accountants (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 (GAAS).

   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.

A. 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.

B. 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.

C. 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

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-4-601.5, 10-4-624, and 42-7-501, 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” means, for the purposes of this regulation, any person in whose name more than twenty-five (25) motor vehicles are registered who wishes to qualify as a self-insurer.

B. “Holding company system” means, for the purposes of this regulation, 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” or “Registration” means, for the purposes of this regulation, 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 Financial Section.

B. Each initial filing shall include the following:

1. Name, address, phone number, and email address of the applicant, and a detailed 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 process and a description of the qualifications and expertise of the personnel providing actuarial and claims handling services.

3. List of motor vehicles registered in the name of the applicant with the year, make, model, and vehicle identification number (VIN) and registration number for each vehicle. The applicant must demonstrate that it will maintain registration of more than 25 motor vehicles throughout the certification period.

4. An applicant shall not self-insure a motor vehicle not registered in its name.

5. In the case of an applicant that is part of 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 vehicles.

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 prior three (3) years for the entire holding company system when the applicant is part of a holding company system.

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 of occurrence, 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 or partial payments. 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 registered in the name of the applicant with the year, make, model, and vehicle identification number (VIN) and registration number for each vehicle. The applicant must demonstrate that it will maintain registration of more than 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, in the state of Colorado and nationally.

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

   b. The report shall be prepared to reconcile with the most recent audited financial statement or most recent consolidated audited financial statement.

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.

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 ninety (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 (2) years of profitable operations out of the most recent three (3) fiscal 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 carrier as defined in § 40-10.1-101(10), C.R.S., or contract carrier as defined in § 40-10.1-101(6), C.R.S., estimating the reserves necessary to pay anticipated claims and costs.

G. The Division will not accept new applications for self-insurance certification utilizing cash deposits or other trusts to secure payment of self-insured obligations.

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 claim register which must include each incident, the date of occurrence, 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 or partial payments.

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 and anticipated duration.

5. A detailed listing of all structured settlements including those amounts transferred to an insurer or other third party 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 for cancellation of the certificate of self-insurance.

Section 8 Cancellation

The Commissioner may cancel a certificate of self-insurance upon five days' notice and after a hearing pursuant to § 10-4-624(2), C.R.S., for the following reasons:

A. Any of the reasons delineated in Section 7.B. of this regulation;

B. Failure to continue to posses the ability to pay all judgments that may be obtained against the self insurer;

C. Failure to pay any benefit as defined in § 10-4-620;

D. Failure to pay any judgment within thirty days after such judgment has become final; or

E. Any other reasonable grounds as determined by the Commissioner.

Section 9 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 10 Confidentiality

Documentation requested by the Division of Insurance and submitted in compliance herewith shall generally be considered a public record under the Colorado Open 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 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 or any applicable statute may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This regulation shall become effective June 1, 2017.

Section 14 History

New regulation effective January 31, 1998.
Amended regulation effective May 1, 2000.
Amended regulation effective February 1, 2004.
Amended regulation effective April 1, 2009.
Amended regulation effective June 1, 2017.

Regulation 2-1-11 VIATICAL SETTLEMENTS

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109 and 10-7-615, C.R.S.

Section 2 Scope 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 Applicability

This regulation applies to all licensed viatical settlement providers, any person seeking a viatical settlement provider license, and life insurance producers negotiating a viatical settlement on behalf of a viator.

Section 4 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. "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 5 License Requirements

A. 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 the health status of the insured or any other matters.

B. 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 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 insurance 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 insurance producers 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 the viators with dependents and without.

E. A viatical settlement provider or life insurance 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 insurance 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 acknowledgement 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.

I. 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 8 Prohibited Practices

A. A viatical settlement provider or life insurance 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 insurance 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 insurance producer negotiating viatical settlements, whether entitled to collect a fee directly or indirectly, in the same viatical settlement.

C. A life insurance 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 insurance 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 certificate holder, 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 life insurance 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 insurance 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 insurance 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 any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of regulation shall not be affected.

Section 11 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 12 Effective Date

This amended regulation shall become effective on September 1, 2012

Section 13 History

Replaces Emergency Regulation 05-E-6 in its entirety
New regulation effective March 1, 2006
Amended regulation effective September 1, 2012

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

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this regulation is to clarify the requirements for the formation and operation of public entity self-insurance pools.

Section 3 Applicability

This regulation shall apply to public entities cooperating with one another to from a self-insurance pool to provide the insurance coverage required by Article 44 of Title 8, C.R.S and authorized by Articles 10 of Title 24 and Article 13 of Title 29, C.R.S.

Section 4 Definitions

A. "Admitted Assets" means, for the purposes of this regulation, 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 eligible 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 (2), 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, for the purposes of this regulation, a pool's surplus is less than required pursuant to this regulation.

C. "Insolvent" means, for the purposes of this regulation, a pool's admitted assets are less than all of its liabilities.

D. "Member" means, for the purposes of this regulation, an entity which participates in a self-insurance pool.

E. "Public entity" means, for the purposes of this regulation, 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" means, for the purposes of this regulation, 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, for the purposes of this regulation, that amount which remains after subtracting the pool’s liabilities from its admitted assets.

Section 5 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; and

   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 Section 8 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.

Section 6 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.

Section 7 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.

Section 8 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.

Section 9 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.

1. Property $100,000

2. Casualty $200,000

3. 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.

Section 10 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 Section 5 of 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.

Section 11 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.

Section 12 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 4 of Colorado Insurance Regulation 3-1-2.

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.

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.

Section 13 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 policies 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.

6. 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 their discretion, may authorize loss reserves to be discounted pursuant to the applicant's request, or may modify the request in any way they see 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.

Section 14 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 semi annually, ratify such investment transactions.

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

D. 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.

E. Claim files must be maintained for at least five years. The original file or an electronic format 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.

Section 15 Reinsurance and Credit for Reserving on Ceded Risks

A. Any reinsurance agreement must meet the requirements as set forth in §§ 10-3-701 et seq., C.R.S., and Colorado Insurance Regulation 3-3-5.

B. Credit for reserves on ceded risks may only be taken if the conditions as set forth in §§ 10-3-701 et seq., C.R.S. are satisfied.

Section 16 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.

Section 17 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 the Commissioner, 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

Section 18 Fidelity Coverage

A. Each pool shall obtain fidelity coverage in accordance with Colorado Insurance Regulation 3-1-1.

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.

Section 19 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.

Section 20 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 21 Enforcement

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

Section 22 Effective Date

This amended regulation shall be effective April 1, 2017.

Section 23 History

Amended and Restated Regulation effective December 31, 1992
Amended Regulation effective October 1, 2012
Amended Regulation effective April 1, 2017

APPENDIX A

NAME OF POOL

DATE OF STATEMENT December 31, or Fiscal Year Ended

A. <u>STATEMENT OF ASSETS, LIABILITIES AND SURPLUS</u>

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. <u>STATEMENT OF INCOME</u>

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)

<u>COVERAGE(S) PROVIDED</u>

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 (printed)

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

Section 1 Authority

This regulation is promulgated under the authority of §§ 8-44-205(9), and 10-1-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to clarify the requirements for the formation and operation of employer's workers' compensation self-insurance pools.

Section 3 Applicability

This regulation shall apply to employers cooperating with one another to form a self-insurance pool to provide the insurance coverage required by Article 44 of Title 8, C.R.S.

Section 4 Definitions

A. "Admitted Assets" means, for the purposes of this regulation, the securities set forth in Section 15 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 accrued for more than ninety days from the date the claim was paid; uncollected premium contributions which are less than ninety days past the effective date of coverage; and recoverable from solvent insurance companies licensed in the State of Colorado or otherwise approved as qualified non-admitted reinsurers.

B. "Board of Directors" means, for the purposes of this regulation, the governing body of the pool consisting of at least five (5) directors.

C. "Commissioner" means, for the purposes of this regulation, the commissioner of insurance.

D. "Deductible" means, for the purposes of this regulation, 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.

E. "Employers" means, for the purposes of this regulation, 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.

F. "Expected level of funding" means, for the purposes of this regulation, the level of funding, as determined by a qualified actuary that provides for expected indemnity and medical losses, and expected allocated loss adjustment expenses.

G. "Impaired" means, for the purposes of this regulation, that a pool's surplus is less than required pursuant to this regulation.

H. "Insolvent" means, for the purposes of this regulation, that a pool's admitted assets are less than all of its liabilities or the pool is unable to pay its obligations.

I. "Member" or "Members" mean, for the purposes of this regulation, an employer which has joined the self insurance pool.

J. "Pool Agreement" means, for the purposes of this regulation, the agreement in which the governing articles of the pool are set forth.

K. "Proposal" means, for the purposes of this regulation, the description of the pool's plan of operation submitted to the Commissioner which shall include fully executed documents and agreements as indentified in Section 5 of this regulation.

L. "Qualified Actuary means, for the purposes of this regulation, an actuary that meets the qualification requirements described in Sections 4 and 5 of Regulation 1-1-1, 3 CCR 702-1.

M. "Self-Insurance pool" or "pool" means, for the purposes of this regulation, a pool formed by employers pursuant to § 8-44-205, C.R.S.

N. “Surplus” means, for the purposes of this regulation, that amount which remains after subtracting the pool’s liabilities from its admitted assets. Subordinated debentures referred to in Section 8 of this regulation, shall not be deemed a liability until repayment of principal and/or interest has been approved by the Commissioner.

O. “Trust Fund” or “Premium Fund” means, for the purposes of this regulation, 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.

Section 5 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. Administrative 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.

Section 6 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. Subjects that 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 pool's certificate of authority pursuant to § 8-44-205(7)(a)(VI) and (VII), C.R.S.; 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.

Section 7 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 18.

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 who 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 an admitted asset and be assigned to the pool.

J. Specifically define insolvency and impairment as set forth in Section 4 of this regulation.

K. Other provisions as applicable and as deemed necessary.

Section 8 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 location 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.

Section 9 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 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 4 of Colorado Insurance Regulation 3-1-2.

Section 10 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.

Section 11 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 5, 8, and 9 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 5.G. of this regulation.

Section 12 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 organization 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 the Commissioner's authorized representative shall have access to all books and records, papers and documents of the pool. Such examinations may consist of an on-site examination or desk audit based on the financial filings, actuarial reports and other information filed with the Commissioner.

Section 13 Records

To facilitate examination of each pool as required by 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 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 discretion 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.

D. Claim files must be maintained for at least seven years. The original file or an electronic format is acceptable. A historical summary of reserve transactions and payments must be incorporated into each claim file.

Section 14 Annual Filing Requirements

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

A. The fiscal year for annual reporting purposes 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 require that a pool report more frequently than annually in 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 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 reports 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 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.

Section 15 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.

Section 16 Reinsurance and Credit for Reserves on Ceded Risks

Credit for reserves on ceded risks may only be taken if the conditions set forth in §§ 10-3-701 et seq., C.R.S., are satisfied.

Section 17 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 pool's limits for employers' liability coverage as determined by the board of directors.

Section 18 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.

Section 19 Fidelity Coverage

Each pool shall maintain fidelity coverage in accordance with Colorado Insurance Regulation 3-1-1.

Section 20 Contract Service Providers

A. Pools shall provide at least thirty (30) days advance 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.

Section 21 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 22 Enforcement

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

Section 23 Effective Date

This amended regulation shall be effective April1, 2017.

Section 24 History

Amended and Restated Regulation effective December 31, 1992
Amended Regulation effective October 1, 2012
Amended Regulation effective April 1, 2017

APPENDIX A

NAME OF POOL____

DATE OF STATEMENT December 31,______________

A **<u>STATEMENT OF ASSETS, LIABILITIES AND SURPLUS</u>**

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) <u>STATEMENT OF INCOME</u>

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) _____________

<u>COVERAGE(S) PROVIDED</u>

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 (printed)

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 § 10-3-701 et. seq., C.R.S. and Colorado 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 § 10-3-701 et. seq., 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 in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This regulation shall become effective January 1, 2017.

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.
Amended Regulation 2-3-1, effective January 1, 2017.

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" ,15 U.S.C. sec 8201 et. seq., as amended. 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, to any producer or Colorado surplus lines broker, as defined by § 10-5-101.2(3), C.R.S., procuring or assisting in the procurement of surplus lines insurance for an insured whose home state, as defined in § 10-5-101.2(7), C.R.S., is Colorado, and any person that enters into an independent procurement for nonadmitted insurance.

Section 4 Disclosure

A. Every insurance contract procured and delivered as a surplus line coverage to an insured whose home state is Colorado must include the disclosure stated in § 10-5-104, C.R.S.

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 eligible 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 eligible 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 eligible 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 eligible nonadmitted insurer.

D. If the insurance transaction is primarily for automobile liability to meet the financial responsibility requirements in Colorado any eligible 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 non admitted insurer that is not listed on the Division of Insurance's eligible 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.

D. In accordance with § 10-5-110(1), C.R.S, the reporting period will be the calendar year. On or before the first day of March each broker and every person that enters into an independent procurement for nonadmitted insurance shall file their statement of, and remit the premium taxes for, all nonadmitted insurance transacted during the preceding calendar year.

Section 8 Eligible 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 non admitted insurer that wants to be included on the Division of Insurance's eligible 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 24-31-104.5, 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 eligible 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 eligible 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 minimum required capital and surplus may make formal request of the Commissioner that they be given consideration for approval as an Eligible 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 in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This amended regulation shall be effective September 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
Amended Regulation effective September 1, 2012

Regulation 2-5-1 CONSUMER GOODS SERVICE CONTRACT PROVIDER REGISTRATION

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-4-1609(5), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements for the registration of providers of service contracts pursuant to the requirements of § 10-4-1603(9)(b), C.R.S.

Section 3 Applicability

This regulation shall apply to all providers of service contracts sold in the state of Colorado, except those specifically excluded in § 10-4-1602, C.R.S.

Section 4 Definitions

A. "Provider", for the purposes of this regulation, shall have the same meaning as found at § 10-4-1601(9), C.R.S.

B. "Service contract", for the purposes of this regulation, shall have the same meaning as found at § 10-4-1601(14), C.R.S.

Section 5 Registration Requirements

A. Providers of service contracts shall register with the Commissioner in accordance with the requirements of § 10-4-1603(9)(b), C.R.S.

B. The requirement to register shall be fulfilled by a provider of service contracts by:

1. Submitting the Consumer Goods Service Contract Provider Registration Form found at Appendix A of this regulation to the Division; and

2. Submitting a complete copy of:

    a. The reimbursement insurance policy issued by a licensed insurer insuring all service contracts; OR

    b. Submitting a copy of the provider's or provider's parent company's most recent Form 10-K or Form 20-F that has been filed with the federal securities and exchange commission, or, if the company does not file with the federal securities and exchange commission, a copy of the company's audited financial statements showing the provider or its parent company has a net worth of at least one hundred million dollars; and

3. One original fully executed Uniform Consent to Service of Process form (NAIC form 12).

C. If there is any change to the information contained in the Consumer Goods Services Contract Provider Registration form, the provider must update its registration information within thirty (30) days of the change. The update shall include all information provided in subsection B. above.

D. Providers of service contracts registering with the Commissioner shall pay a fee in the amount of $500 upon registration, and annually thereafter, to defray the cost for processing and maintaining the registration information, pursuant to the requirements found at § 10-4-1603(9)(b)(II), C.R.S.

E. Registration must be renewed annually by March 31 of each subsequent year after initial registration.

Section 6 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 7 Enforcement

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

Section 8 Effective Date

This regulation shall become effective March 15, 2015.

Section 9 History

New regulation effective March 15, 2015.

Appendix A: Consumer Goods Service Contract Provider Registration Form (§ 10-4-1603 C.R.S)

Filing Fee $500.00
Due March 31, Annually Year ________

Legal Name of Service Contract Provider:
D.B.A. (if applicable):
FEIN #:

Applicant's state of domicile and date of incorporation:
Corporate Address:

Contact Person:
Title:
Telephone number:
Email Address:

Service of Process Agent Name: (Submit a completed Service of Process form as an attachment to this Application)

Administrator Name and Contact Person (if applicable):
Administrator Telephone number and email address:

The Provider must meet one of the following requirements in order to qualify as a Service Contract Provider:

1) Does the Provider have a reimbursement insurance policy issued by a licensed insurer insuring all service contracts? Yes _____ No _____ If yes, please provide the following:

   a.) Name of Insurer and NAIC#:
   b.) Insurance Policy Number and Policy Period:
   c.) Attach a copy of the complete policy.

Or

2) Does the Provider maintain, or together with its parent maintain, a net worth or stockholders' equity of at least one hundred million ($100,000,000) dollars? Yes _____ No _____ If yes, provide either:

   a.) A copy of Applicant's most recent Form 10-K, Form 20-F, or
   b.) A copy of the Applicant's most recent audited financial statements, or
   c.) A copy of the parent company's most recent Form 10-K or Form 20-F or parent company's audited financial statements, and
   d.) A guarantee agreement from the parent company which guarantees the obligation of the provider relating to service contracts sold by the provider in this state.

I hereby certify that all of the information contained in this application and its attachments is true and complete. I acknowledge that providing false and misleading information in the application, or omitting pertinent or material information in connection with this registration application is sufficient grounds for administrative action by the commissioner and potentially, applicable civil penalties.

Signature: Title:
Printed Name: Date:

Note: If any of the information provided on this form changes, the applicant must provide a written notice to the Commissioner within 30 days after the change.

Please send the $500.00 check payable to:

Colorado Division of Insurance
Attn: Cash Management
1560 Broadway, Suite 850
Denver, CO 80202

Email inquiries to: DORA_INS_CORPORATEAFFAIRS@STATE.CO.US

Uniform Consent to Service of Process NAIC Form 12 can be found at:
http://www.naic.org/documents/industry_ucaa_form12.pdf

Regulation 2-6-1 [Repealed eff. 09/01/2012]

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 eff. 03/01/2012. Regulation 2-1-4 repealed eff. 03/01/2012.
Regulation 2-1-5 repealed eff. 06/01/2012.
Regulation 2-1-8 eff. 07/01/2012.
Regulations 2-1-11, 2-4-1 eff. 09/01/2012. Regulation 2-6-1 repealed eff. 09/01/2012.
Regulations 2-2-1-2-2-2 eff. 10/01/2012.
Regulations 2-1-1, 2-1-3 eff. 11/01/2012.
Regulation 2-1-2 eff. 08/01/2013.
Regulation 2-5-1 eff. 03/15/2015.
Regulation 2-1-9 eff. 02/01/2016.
Regulations 2-1-7, 2-3-1 eff. 01/01/2017.
Regulations 2-2-1, 2-2-2 eff. 04/01/2017.
Regulation 2-1-10 eff. 06/01/2017.
Regulation 2-1-8 eff. 10/01/2017.